

104TH CONGRESS
2D SESSION

H. R. 3103

To amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 18, 1996

Mr. ARCHER (for himself and Mr. THOMAS) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committees on Economic and Educational Opportunities, Commerce, and the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

2 (a) SHORT TITLE.—This Act may be cited as the
 3 “Health Coverage Availability and Affordability Act of
 4 1996”.

5 (b) TABLE OF CONTENTS.—The table of contents of
 6 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—IMPROVED AVAILABILITY AND PORTABILITY OF
 HEALTH INSURANCE COVERAGE

Subtitle A—Coverage Under Group Health Plans

Sec. 101. Portability of coverage for previously covered individuals.

Sec. 102. Limitation on preexisting condition exclusions; no application to cer-
 tain newborns, adopted children, and pregnancy.

Sec. 103. Prohibiting exclusions based on health status and providing for en-
 rollment periods.

Sec. 104. Enforcement.

Subtitle B—Definitions; General Provisions

Sec. 191. Definitions; scope of coverage.

Sec. 192. State flexibility to provide greater protection.

Sec. 193. Effective date.

Sec. 194. Rule of construction.

TITLE II—PREVENTING HEALTH CARE FRAUD AND ABUSE;
 ADMINISTRATIVE SIMPLIFICATION

Sec. 200. References in title.

Subtitle A—Fraud and Abuse Control Program

Sec. 201. Fraud and abuse control program.

Sec. 202. Medicare integrity program.

Sec. 203. Beneficiary incentive programs.

Sec. 204. Application of certain health anti-fraud and abuse sanctions to fraud
 and abuse against Federal health care programs.

Sec. 205. Guidance regarding application of health care fraud and abuse sanc-
 tions.

Subtitle B—Revisions to Current Sanctions for Fraud and Abuse

Sec. 211. Mandatory exclusion from participation in medicare and State health
 care programs.

Sec. 212. Establishment of minimum period of exclusion for certain individuals
 and entities subject to permissive exclusion from medicare and
 State health care programs.

Sec. 213. Permissive exclusion of individuals with ownership or control interest
 in sanctioned entities.

- Sec. 214. Sanctions against practitioners and persons for failure to comply with statutory obligations.
- Sec. 215. Intermediate sanctions for medicare health maintenance organizations.
- Sec. 216. Additional exception to anti-kickback penalties for discounting and managed care arrangements.
- Sec. 217. Criminal penalty for fraudulent disposition of assets in order to obtain medicaid benefits.
- Sec. 218. Effective date.

Subtitle C—Data Collection

- Sec. 221. Establishment of the health care fraud and abuse data collection program.

Subtitle D—Civil Monetary Penalties

- Sec. 231. Social security act civil monetary penalties.
- Sec. 232. Clarification of level of intent required for imposition of sanctions.
- Sec. 233. Penalty for false certification for home health services.

Subtitle E—Revisions to Criminal Law

- Sec. 241. Definition of Federal health care offense.
- Sec. 242. Health care fraud.
- Sec. 243. Theft or embezzlement.
- Sec. 244. False statements.
- Sec. 245. Obstruction of criminal investigations of health care offenses.
- Sec. 246. Laundering of monetary instruments.
- Sec. 247. Injunctive relief relating to health care offenses.
- Sec. 248. Authorized investigative demand procedures.
- Sec. 249. Forfeitures for Federal health care offenses.

Subtitle F—Administrative Simplification

PART 1—GENERAL ADMINISTRATIVE SIMPLIFICATION

- Sec. 251. Purpose.
- Sec. 252. Administrative simplification.

“PART C—ADMINISTRATIVE SIMPLIFICATION

- “Sec. 1171. Definitions.
- “Sec. 1172. General requirements for adoption of standards.
- “Sec. 1173. Standards for information transactions and data elements.
- “Sec. 1174. Timetables for adoption of standards.
- “Sec. 1175. Requirements.
- “Sec. 1176. General penalty for failure to comply with requirements and standards.
- “Sec. 1177. Wrongful disclosure of individually identifiable health information.
- “Sec. 1178. Effect on State law.
- “Sec. 1179. Health Information Advisory Committee.”.

PART 2—ADMINISTRATIVE SIMPLIFICATION FOR LABORATORY SERVICES

- Sec. 261. Administrative simplification for laboratory services.

TITLE III—TAX-RELATED HEALTH PROVISIONS

Sec. 300. Amendment of 1986 Code.

Subtitle A—Medical Savings Accounts

Sec. 301. Medical savings accounts.

Subtitle B—Increase in Deduction for Health Insurance Costs of Self-Employed Individuals

Sec. 311. Increase in deduction for health insurance costs of self-employed individuals.

Subtitle C—Long-Term Care Services and Contracts

PART I—GENERAL PROVISIONS

Sec. 321. Treatment of long-term care insurance.

Sec. 322. Premiums for qualified long-term care insurance treated as payment for medical care.

Sec. 323. Reporting requirements.

PART II—CONSUMER PROTECTION PROVISIONS

Sec. 325. Policy requirements.

Sec. 326. Requirements for issuers of long-term care insurance policies.

Sec. 327. Coordination with State requirements.

Sec. 328. Effective dates.

Subtitle D—Treatment of Accelerated Death Benefits

Sec. 331. Treatment of accelerated death benefits by recipient.

Sec. 332. Tax treatment of companies issuing qualified accelerated death benefit riders.

Subtitle E—High-Risk Pools

Sec. 341. Exemption from income tax for State-sponsored organizations providing health coverage for high-risk individuals.

TITLE IV—REVENUE OFFSETS

Sec. 400. Amendment of 1986 Code.

Subtitle A—Repeal of Bad Debt Reserve Method for Thrift Savings Associations

Sec. 401. Repeal of bad debt reserve method for thrift savings associations.

Subtitle B—Reform of the Earned Income Credit

Sec. 411. Earned income credit denied to individuals not authorized to be employed in the United States.

Sec. 412. Provisions to improve tax compliance.

1 **TITLE I—IMPROVED AVAILABIL-**
 2 **ITY AND PORTABILITY OF**
 3 **HEALTH INSURANCE COV-**
 4 **ERAGE**

5 **Subtitle A—Coverage Under Group**
 6 **Health Plans**

7 **SEC. 101. PORTABILITY OF COVERAGE FOR PREVIOUSLY**
 8 **COVERED INDIVIDUALS.**

9 (a) CREDITING PERIODS OF PREVIOUS COVERAGE
 10 TOWARD PREEXISTING CONDITION RESTRICTIONS.—Sub-
 11 ject to the succeeding provisions of this section, a group
 12 health plan, and an insurer or health maintenance organi-
 13 zation offering health insurance coverage in connection
 14 with a group health plan, shall provide that any preexist-
 15 ing condition limitation period (as defined in subsection
 16 (b)(2)) is reduced by the length of the aggregate period
 17 of qualified prior coverage (if any, as defined in subsection
 18 (b)(3)) applicable to the participant or beneficiary as of
 19 the date of commencement of coverage under the plan.

20 (b) DEFINITIONS AND OTHER PROVISIONS RELAT-
 21 ING TO PREEXISTING CONDITIONS.—

22 (1) PREEXISTING CONDITION.—

23 (A) IN GENERAL.—For purposes of this
 24 subtitle, subject to subparagraph (B), the term
 25 “preexisting condition” means a condition, re-

1 regardless of the cause of the condition, for which
 2 medical advice, diagnosis, care, or treatment
 3 was recommended or received within the 6-
 4 month period ending on the day before—

5 (i) the effective date of the coverage
 6 of such participant or beneficiary, or

7 (ii) the earliest date upon which such
 8 coverage could have been effective if there
 9 were no waiting period applicable,

10 whichever is earlier.

11 (B) EXTENSION OF PERIOD IN THE CASE
 12 OF LATE ENROLLMENT.—In the case of a par-
 13 ticipant or beneficiary whose initial coverage
 14 commences after the date the participant or
 15 beneficiary first becomes eligible for coverage
 16 under the group health plan, the reference in
 17 subparagraph (A) to “6-month period” is
 18 deemed a reference to “12-month period”.

19 (2) PREEXISTING CONDITION LIMITATION PE-
 20 RIOD.—For purposes of this subtitle, the term “pre-
 21 existing condition limitation period” means, with re-
 22 spect to coverage of an individual under a group
 23 health plan or under health insurance coverage, the
 24 period during which benefits with respect to treat-
 25 ment of a condition of such individual are not pro-

1 vided based on the fact that the condition is a pre-
2 existing condition.

3 (3) AGGREGATE PERIOD OF QUALIFIED PRIOR
4 COVERAGE.—

5 (A) IN GENERAL.—For purposes of this
6 section, the term “aggregate period of qualified
7 prior coverage” means, with respect to com-
8 mencement of coverage of an individual under
9 a group health plan or health insurance cov-
10 erage offered in connection with a group health
11 plan, the aggregate of the qualified coverage pe-
12 riods (as defined in subparagraph (B)) of such
13 individual occurring before the date of such
14 commencement. Such period shall be treated as
15 zero if there is more than a 60-day break in
16 coverage under a group health plan (or health
17 insurance coverage offered in connection with
18 such a plan) between the date the most recent
19 qualified coverage period ends and the date of
20 such commencement.

21 (B) QUALIFIED COVERAGE PERIOD.—

22 (i) IN GENERAL.—For purposes of
23 this paragraph, subject to subsection (c),
24 the term “qualified coverage period”
25 means, with respect to an individual, any

1 period of coverage of the individual under
2 a group health plan, health insurance cov-
3 erage, or under title XVIII or XIX of the
4 Social Security Act.

5 (ii) DISREGARDING PERIODS BEFORE
6 BREAKS IN COVERAGE.—Such term does
7 not include any period occurring before
8 any 60-day break in coverage described in
9 subparagraph (A).

10 (C) WAITING PERIOD NOT TREATED AS A
11 BREAK IN COVERAGE.—For purposes of sub-
12 paragraphs (A) and (B), any period that is in
13 a waiting period for any coverage under a
14 group health plan (or for health insurance cov-
15 erage offered in connection with a group health
16 plan) shall not be considered to be a break in
17 coverage described in subparagraph (B)(ii).

18 (D) ESTABLISHMENT OF PERIOD.—A
19 qualified coverage period with respect to an in-
20 dividual shall be established through presen-
21 tation of certifications described in subsection
22 (c) or in such other manner as may be specified
23 in regulations to carry out this section.

24 (c) CERTIFICATIONS OF COVERAGE; CONFORMING

25 COVERAGE.—

1 (1) IN GENERAL.—The plan administrator of a
2 group health plan, or the insurer or HMO offering
3 health insurance coverage in connection with a group
4 health plan, shall, on request made on behalf of an
5 individual covered (or previously covered within the
6 previous 18 months) under the plan or coverage,
7 provide for a certification of the period of coverage
8 of the individual under such plan or coverage and of
9 the waiting period (if any) imposed with respect to
10 the individual for any coverage under the plan.

11 (2) STANDARD METHOD.—Subject to paragraph
12 (3), a group health plan, or insurer or HMO offering
13 health insurance coverage in connection with a group
14 health plan, shall determine qualified coverage peri-
15 ods under subsection (b)(3)(B) by including all peri-
16 ods described in such subsection, without regard to
17 the specific benefits offered during such a period.

18 (3) ALTERNATIVE METHOD.—Such a plan, in-
19 surer, or HMO may elect to make such determina-
20 tion on a benefit-specific basis for all participants
21 and beneficiaries and not to include as a qualified
22 coverage period with respect to a specific benefit
23 coverage during a previous period unless such pre-
24 vious coverage for that benefit was included at the

1 end of the most recent period of coverage. In the
2 case of such an election—

3 (A) the plan, insurer, or HMO shall promi-
4 nently state in any disclosure statements con-
5 cerning the plan or coverage and to each en-
6 rollee at the time of enrollment under the plan
7 (or at the time the health insurance coverage is
8 offered for sale in the group health market)
9 that the plan or coverage has made such elec-
10 tion and shall include a description of the effect
11 of this election; and

12 (B) upon the request of the plan, insurer,
13 or HMO, the entity providing a certification
14 under paragraph (1)—

15 (i) shall promptly disclose to the re-
16 questing plan, insurer, or HMO the plan
17 statement (insofar as it relates to health
18 benefits under the plan) or other detailed
19 benefit information on the benefits avail-
20 able under the previous plan or coverage,
21 and

22 (ii) may charge for the reasonable
23 cost of providing such information.

1 **SEC. 102. LIMITATION ON PREEXISTING CONDITION EXCLU-**
2 **SIONS; NO APPLICATION TO CERTAIN**
3 **NEWBORNS, ADOPTED CHILDREN, AND PREG-**
4 **NANCY.**

5 (a) LIMITATION OF PERIOD.—

6 (1) IN GENERAL.—Subject to the succeeding
7 provisions of this section, a group health plan, and
8 an insurer or HMO offering health insurance cov-
9 erage in connection with a group health plan, shall
10 provide that any preexisting condition limitation pe-
11 riod (as defined in section 101(b)(2)) does not ex-
12 ceed 12 months, counting from the effective date of
13 coverage.

14 (2) EXTENSION OF PERIOD IN THE CASE OF
15 LATE ENROLLMENT.—In the case of a participant or
16 beneficiary whose initial coverage commences after
17 the date the participant or beneficiary first becomes
18 eligible for coverage under the group health plan,
19 the reference in paragraph (1) to “12 months” is
20 deemed a reference to “18 months”.

21 (b) EXCLUSION NOT APPLICABLE TO CERTAIN
22 NEWBORNS AND CERTAIN ADOPTIONS.—

23 (1) IN GENERAL.—Subject to paragraph (2), a
24 group health plan, and an insurer or HMO offering
25 health insurance coverage in connection with a group
26 health plan, may not provide any limitation on bene-

1 fits based on the existence of a preexisting condition
2 in the case of—

3 (A) an individual who within the 30-day
4 period beginning with the date of birth, or

5 (B) an adopted child or a child placed for
6 adoption beginning at the time of adoption or
7 placement if the individual, within the 30-day
8 period beginning on the date of adoption or
9 placement,

10 becomes covered under a group health plan or other-
11 wise becomes covered under health insurance cov-
12 erage (or covered for medical assistance under title
13 XIX of the Social Security Act).

14 (2) LOSS IF BREAK IN COVERAGE.—Paragraph
15 (1) shall no longer apply to an individual if the indi-
16 vidual does not have any coverage under a group
17 health plan, health insurance coverage, or under title
18 XVIII or XIX of the Social Security Act for a con-
19 tinuous period of 60 days, not counting in such pe-
20 riod any days that are in a waiting period for any
21 coverage under a group health plan.

22 (3) PLACED FOR ADOPTION DEFINED.—In this
23 subsection and section 103(d), the term “place-
24 ment”, or being “placed”, for adoption, in connec-
25 tion with any placement for adoption of a child with

1 any person, means the assumption and retention by
2 such person of a legal obligation for total or partial
3 support of such child in anticipation of adoption of
4 such child. The child's placement with such person
5 terminates upon the termination of such legal obliga-
6 tion.

7 (c) EXCLUSION NOT APPLICABLE TO PREGNANCY.—
8 For purposes of this section, pregnancy shall not be treat-
9 ed as a preexisting condition.

10 (d) ELIGIBILITY PERIOD IMPOSED BY HEALTH
11 MAINTENANCE ORGANIZATIONS AS ALTERNATIVE TO
12 PREEXISTING CONDITION LIMITATION.—A health mainte-
13 nance organization which offers health insurance coverage
14 in connection with a group health plan and which does
15 not use the preexisting condition limitations allowed under
16 this section and section 101 with respect to any particular
17 coverage option may impose an eligibility period for such
18 coverage option, but only if such period does not exceed—

19 (1) 90 days, in the case of a participant or ben-
20 eficiary whose initial coverage commences at the
21 time such participant or beneficiary first becomes el-
22 igible for coverage under the plan, or

23 (2) 180 days, in the case of a participant or
24 beneficiary whose initial coverage commences after

1 the date on which such participant or beneficiary
 2 first becomes eligible for coverage.

3 For purposes of this subsection, the term “eligibility pe-
 4 riod” means a period which, under the terms of the health
 5 insurance coverage offered by the health maintenance or-
 6 ganization, must expire before the health insurance cov-
 7 erage becomes effective. Any such eligibility period shall
 8 be treated for purposes of this subtitle as a waiting period
 9 under the plan and shall run concurrently with any other
 10 applicable waiting period under the plan.

11 **SEC. 103. PROHIBITING EXCLUSIONS BASED ON HEALTH**
 12 **STATUS AND PROVIDING FOR ENROLLMENT**
 13 **PERIODS.**

14 (a) PROHIBITION OF EXCLUSION OF PARTICIPANTS
 15 OR BENEFICIARIES BASED ON HEALTH STATUS.—

16 (1) IN GENERAL.—A group health plan, and an
 17 insurer or HMO offering health insurance coverage
 18 in connection with a group health plan, may not ex-
 19 clude an employee or his or her beneficiary from
 20 being (or continuing to be) a participant or bene-
 21 ficiary under the terms of such plan or coverage
 22 based on health status (as defined in section
 23 191(c)(6)).

24 (2) CONSTRUCTION.—Nothing in this sub-
 25 section shall be construed as preventing the estab-

1 lishment of preexisting condition limitations and re-
2 strictions to the extent consistent with the provisions
3 of this subtitle.

4 (b) ENROLLMENT OF ELIGIBLE INDIVIDUALS WHO
5 LOSE OTHER COVERAGE.—A group health plan shall per-
6 mit an uncovered employee who is otherwise eligible for
7 coverage under the terms of the plan (or an uncovered
8 dependent, as defined under the terms of the plan, of such
9 an employee, if family coverage is available) to enroll for
10 coverage under the plan under at least one benefit option
11 if each of the following conditions is met:

12 (1) The employee or dependent was covered
13 under a group health plan or had health insurance
14 coverage at the time coverage was previously offered
15 to the employee or individual.

16 (2) The employee stated in writing at such time
17 that coverage under a group health plan or health
18 insurance coverage was the reason for declining en-
19 rollment.

20 (3) The employee or dependent lost coverage
21 under a group health plan or health insurance cov-
22 erage (as a result of loss of eligibility for the cov-
23 erage, termination of employment, or reduction in
24 the number of hours of employment).

1 (4) The employee requests such enrollment
2 within 30 days after the date of termination of such
3 coverage.

4 (c) DEPENDENT BENEFICIARIES.—

5 (1) IN GENERAL.—If a group health plan
6 makes family coverage available, the plan may not
7 require, as a condition of coverage of an individual
8 as a dependent (as defined under the terms of the
9 plan) of a participant in the plan, a waiting period
10 applicable to the coverage of a dependent who—

11 (A) is a newborn,

12 (B) is an adopted child or child placed for
13 adoption (within the meaning of section
14 102(b)(3)), at the time of adoption or place-
15 ment, or

16 (C) is a spouse, at the time of marriage,
17 if the participant has met any waiting period appli-
18 cable to that participant.

19 (2) TIMELY ENROLLMENT.—

20 (A) IN GENERAL.—Enrollment of a partici-
21 pant's beneficiary described in paragraph (1)
22 shall be considered to be timely if a request for
23 enrollment is made within 30 days of the date
24 family coverage is first made available or, in the
25 case described in—

1 (i) paragraph (1)(A), within 30 days
2 of the date of the birth,

3 (ii) paragraph (1)(B), within 30 days
4 of the date of the adoption or placement
5 for adoption, or

6 (iii) paragraph (1)(C), within 30 days
7 of the date of the marriage with such a
8 beneficiary who is the spouse of the partic-
9 ipant,
10 if family coverage is available as of such date.

11 (B) COVERAGE.—If available coverage in-
12 cludes family coverage and enrollment is made
13 under such coverage on a timely basis under
14 subparagraph (A), the coverage shall become ef-
15 fective not later than the first day of the first
16 month beginning 15 days after the date the
17 completed request for enrollment is received.

18 **SEC. 104. ENFORCEMENT.**

19 (a) ENFORCEMENT THROUGH COBRA PROVISIONS
20 IN INTERNAL REVENUE CODE.—

21 (1) APPLICATION OF COBRA SANCTIONS.—Sub-
22 section (a) of section 4980B of the Internal Revenue
23 Code of 1986 is amended by striking “the require-
24 ments of” and all that follows and inserting “the re-
25 quirements of—

1 “(1) subsection (f) with respect to any qualified
2 beneficiary, or

3 “(2) subject to subsection (h)—

4 “(A) section 101 or 102 of the Health
5 Coverage Availability and Affordability Act of
6 1996 with respect to any individual covered
7 under the group health plan, or

8 “(B) section 103 of such Act with respect
9 to any individual.”.

10 (2) NOTICE REQUIREMENT.—Section
11 4980B(f)(6)(A) of such Code is amended by insert-
12 ing before the period the following: “and subtitle A
13 of title I of the Health Coverage Availability and Af-
14 fordability Act of 1996”.

15 (3) SPECIAL RULES.—Section 4980B of such
16 Code is amended by adding at the end the following:

17 “(h) SPECIAL RULES.—For purposes of applying this
18 section in the case of requirements described in subsection
19 (a)(2) relating to section 101, section 102, or section 103
20 of the Health Coverage Availability and Affordability Act
21 of 1996—

22 “(1) IN GENERAL.—

23 “(A) DEFINITION OF GROUP HEALTH
24 PLAN.—The term ‘group health plan’ has the
25 meaning given such term in section 191(a) of

1 the Health Coverage Availability and Afford-
2 ability Act of 1996.

3 “(B) QUALIFIED BENEFICIARY.—Sub-
4 sections (b), (c), and (e) shall be applied by
5 substituting the term ‘individual’ for the term
6 ‘qualified beneficiary’ each place it appears.

7 “(C) NONCOMPLIANCE PERIOD.—Clause
8 (ii) of subsection (b)(2)(B) and the second sen-
9 tence of subsection (b)(2) shall not apply.

10 “(D) LIMITATION ON TAX.—Subparagraph
11 (B) of subsection (c)(3) shall not apply.

12 “(E) LIABILITY FOR TAX.—Paragraph (2)
13 of subsection (e) shall not apply.

14 “(2) DEFERRAL TO STATE REGULATION.—No
15 tax shall be imposed by this section on any failure
16 to meet the requirements of such section by any en-
17 tity which offers health insurance coverage and
18 which is an insurer or health maintenance organiza-
19 tion (as defined in section 191(c) of the Health Cov-
20 erage Availability and Affordability Act of 1996)
21 regulated by a State if the Secretary of Health and
22 Human Services has made the determination de-
23 scribed in section 104(c)(2) of such Act with respect
24 to such State, section, and entity.

1 “(3) LIMITATION FOR INSURED PLANS.—In the
2 case of a group health plan of a small employer (as
3 defined in section 191 of the Health Coverage Avail-
4 ability and Affordability Act of 1996) that provides
5 health care benefits solely through a contract with
6 an insurer or health maintenance organization (as
7 defined in such section), no tax shall be imposed by
8 this section upon the employer on a failure to meet
9 such requirements if the failure is solely because of
10 the product offered by the insurer or organization
11 under such contract.

12 “(4) LIMITATION ON IMPOSITION OF TAX.—In
13 no case shall a tax be imposed by this section for a
14 failure to meet such a requirement if—

15 “(A) a civil money penalty has been im-
16 posed by the Secretary of Labor under part 5
17 of subtitle A of title I of the Employee Retire-
18 ment Income Security Act of 1974 with respect
19 to such failure, or

20 “(B) a civil money penalty has been im-
21 posed by the Secretary of Health and Human
22 Services under section 104(c) of the Health
23 Coverage Availability and Affordability Act of
24 1996 with respect to such failure.”.

1 (b) ENFORCEMENT THROUGH ERISA SANCTIONS
2 FOR CERTAIN GROUP HEALTH PLANS.—

3 (1) IN GENERAL.—Subject to the succeeding
4 provisions of this subsection, sections 101 through
5 103 of this subtitle shall be deemed to be provisions
6 of title I of the Employee Retirement Income Secu-
7 rity Act of 1974 for purposes of applying such title.

8 (2) FEDERAL ENFORCEMENT ONLY IF NO EN-
9 FORCEMENT THROUGH STATE.—The Secretary of
10 Labor shall enforce each section referred to in para-
11 graph (1) with respect to any entity which is an in-
12 surer or health maintenance organization regulated
13 by a State only if the Secretary of Labor determines
14 that such State has not provided for enforcement of
15 State laws which govern the same matters as are
16 governed by such section and which require compli-
17 ance by such entity with at least the same require-
18 ments as those provided under such section.

19 (3) LIMITATIONS ON LIABILITY.—

20 (A) NO APPLICATION WHERE FAILURE
21 NOT DISCOVERED EXERCISING REASONABLE
22 DILIGENCE.—No liability shall be imposed
23 under this subsection on the basis of any failure
24 during any period for which it is established to
25 the satisfaction of the Secretary of Labor that

1 none of the persons against whom the liability
2 would be imposed knew, or exercising reason-
3 able diligence would have known, that such fail-
4 ure existed.

5 (B) NO APPLICATION WHERE FAILURE
6 CORRECTED WITHIN 30 DAYS.—No liability
7 shall be imposed under this subsection on the
8 basis of any failure if such failure was due to
9 reasonable cause and not to willful neglect, and
10 such failure is corrected during the 30-day pe-
11 riod beginning on the first day any of the per-
12 sons against whom the liability would be im-
13 posed knew, or exercising reasonable diligence
14 would have known, that such failure existed.

15 (4) AVOIDING DUPLICATION OF CERTAIN PEN-
16 ALTIES.—In no case shall a civil money penalty be
17 imposed under the authority provided under para-
18 graph (1) for a violation of this subtitle for which
19 an excise tax has been imposed under section 4980B
20 of the Internal Revenue Code of 1986 or a civil
21 money penalty imposed under subsection (c).

22 (c) ENFORCEMENT THROUGH CIVIL MONEY PEN-
23 ALTIES.—

24 (1) IMPOSITION.—

1 (A) IN GENERAL.—Subject to the succeed-
2 ing provisions of this subsection, any group
3 health plan, insurer, or organization that fails
4 to meet a requirement of this subtitle is subject
5 to a civil money penalty under this section.

6 (B) LIABILITY FOR PENALTY.—Rules simi-
7 lar to the rules described in section 4980B(e) of
8 the Internal Revenue Code of 1986 for liability
9 for a tax imposed under section 4980B(a) of
10 such Code shall apply to liability for a penalty
11 imposed under subparagraph (A).

12 (C) AMOUNT OF PENALTY.—

13 (i) IN GENERAL.—The maximum
14 amount of penalty imposed under this
15 paragraph is \$100 for each day for each
16 individual with respect to which such a
17 failure occurs.

18 (ii) CONSIDERATIONS IN IMPOSI-
19 TION.—In determining the amount of any
20 penalty to be assessed under this para-
21 graph, the Secretary of Health and Human
22 Services shall take into account the pre-
23 vious record of compliance of the person
24 being assessed with the applicable require-
25 ments of this subtitle, the gravity of the

1 violation, and the overall limitations for
2 unintentional failures provided under sec-
3 tion 4980B(c)(4) of the Internal Revenue
4 Code of 1986.

5 (iii) LIMITATIONS.—

6 (I) PENALTY NOT TO APPLY
7 WHERE FAILURE NOT DISCOVERED
8 EXERCISING REASONABLE DILI-
9 GENCE.—No civil money penalty shall
10 be imposed under this paragraph on
11 any failure during any period for
12 which it is established to the satisfac-
13 tion of the Secretary that none of the
14 persons against whom the penalty
15 would be imposed knew, or exercising
16 reasonable diligence would have
17 known, that such failure existed.

18 (II) PENALTY NOT TO APPLY TO
19 FAILURES CORRECTED WITHIN 30
20 DAYS.—No civil money penalty shall
21 be imposed under this paragraph on
22 any failure if such failure was due to
23 reasonable cause and not to willful ne-
24 glect, and such failure is corrected
25 during the 30-day period beginning on

1 the first day any of the persons
2 against whom the penalty would be
3 imposed knew, or exercising reason-
4 able diligence would have known, that
5 such failure existed.

6 (D) ADMINISTRATIVE REVIEW.—

7 (i) OPPORTUNITY FOR HEARING.—

8 The person assessed shall be afforded an
9 opportunity for hearing by the Secretary
10 upon request made within 30 days after
11 the date of the issuance of a notice of as-
12 sessment. In such hearing the decision
13 shall be made on the record pursuant to
14 section 554 of title 5, United States Code.
15 If no hearing is requested, the assessment
16 shall constitute a final and unappealable
17 order.

18 (ii) HEARING PROCEDURE.—If a
19 hearing is requested, the initial agency de-
20 cision shall be made by an administrative
21 law judge, and such decision shall become
22 the final order unless the Secretary modi-
23 fies or vacates the decision. Notice of in-
24 tent to modify or vacate the decision of the
25 administrative law judge shall be issued to

1 the parties within 30 days after the date
2 of the decision of the judge. A final order
3 which takes effect under this paragraph
4 shall be subject to review only as provided
5 under subparagraph (D).

6 (E) JUDICIAL REVIEW.—

7 (i) FILING OF ACTION FOR REVIEW.—

8 Any person against whom an order impos-
9 ing a civil money penalty has been entered
10 after an agency hearing under this para-
11 graph may obtain review by the United
12 States district court for any district in
13 which such person is located or the United
14 States District Court for the District of
15 Columbia by filing a notice of appeal in
16 such court within 30 days from the date of
17 such order, and simultaneously sending a
18 copy of such notice by registered mail to
19 the Secretary.

20 (ii) CERTIFICATION OF ADMINISTRA-

21 TIVE RECORD.—The Secretary shall
22 promptly certify and file in such court the
23 record upon which the penalty was im-
24 posed.

1 (iii) STANDARD FOR REVIEW.—The
2 findings of the Secretary shall be set aside
3 only if found to be unsupported by sub-
4 stantial evidence as provided by section
5 706(2)(E) of title 5, United States Code.

6 (iv) APPEAL.—Any final decision,
7 order, or judgment of such district court
8 concerning such review shall be subject to
9 appeal as provided in chapter 83 of title 28
10 of such Code.

11 (F) FAILURE TO PAY ASSESSMENT; MAIN-
12 TENANCE OF ACTION.—

13 (i) FAILURE TO PAY ASSESSMENT.—If
14 any person fails to pay an assessment after
15 it has become a final and unappealable
16 order, or after the court has entered final
17 judgment in favor of the Secretary, the
18 Secretary shall refer the matter to the At-
19 torney General who shall recover the
20 amount assessed by action in the appro-
21 priate United States district court.

22 (ii) NONREVIEWABILITY.—In such ac-
23 tion the validity and appropriateness of the
24 final order imposing the penalty shall not
25 be subject to review.

1 (G) PAYMENT OF PENALTIES.—Except as
2 otherwise provided, penalties collected under
3 this paragraph shall be paid to the Secretary
4 (or other officer) imposing the penalty and shall
5 be available without appropriation and until ex-
6 pended for the purpose of enforcing the provi-
7 sions with respect to which the penalty was im-
8 posed.

9 (2) FEDERAL ENFORCEMENT ONLY IF NO EN-
10 FORCEMENT THROUGH STATE.—Paragraph (1) shall
11 apply to enforcement of the requirements of section
12 101, 102, or 103 with respect to any entity which
13 offers health insurance coverage and which is an in-
14 surer or HMO regulated by a State only if the Sec-
15 retary of Health and Human Services has deter-
16 mined that such State has not provided for enforce-
17 ment of State laws which govern the same matters
18 as are governed by such section and which require
19 compliance by such entity with at least the same re-
20 quirements as those provided under such section.

21 (3) NONDUPLICATION OF SANCTIONS.—In no
22 case shall a civil money penalty be imposed under
23 this subsection for a violation of this subtitle for
24 which an excise tax has been imposed under section
25 4980B of the Internal Revenue Code of 1986 or for

1 which a civil money penalty has been imposed under
2 the authority provided under subsection (b).

3 (d) COORDINATION IN ADMINISTRATION.—The Sec-
4 retaries of the Treasury, Labor, and Health and Human
5 Services shall issue regulations that are nonduplicative to
6 carry out this subtitle. Such regulations shall be issued
7 in a manner that assures coordination and nonduplication
8 in their activities under this subtitle.

9 **Subtitle B—Definitions; General** 10 **Provisions**

11 **SEC. 191. DEFINITIONS; SCOPE OF COVERAGE.**

12 (a) GROUP HEALTH PLAN.—

13 (1) DEFINITION.—Subject to the succeeding
14 provisions of this subsection and subsection (d)(1),
15 the term “group health plan” means an employee
16 welfare benefit plan to the extent that the plan pro-
17 vides medical care (as defined in subsection (c)(9))
18 to employees or their dependents (as defined under
19 the terms of the plan) directly or through insurance,
20 reimbursement, or otherwise, and includes a group
21 health plan (within the meaning of section
22 5000(b)(1) of the Internal Revenue Code of 1986).

23 (2) LIMITATION OF REQUIREMENTS TO PLANS
24 WITH 2 OR MORE EMPLOYEE PARTICIPANTS.—The
25 requirements of subtitle A shall apply in the case of

1 a group health plan for any plan year, or for health
 2 insurance coverage offered in connection with a
 3 group health plan for a year, only if the group
 4 health plan has two or more participants as current
 5 employees on the first day of the plan year.

6 (3) EXCLUSION OF PLANS WITH LIMITED COV-
 7 ERAGE.—An employee welfare benefit plan shall be
 8 treated as a group health plan under this title only
 9 with respect to medical care which is provided under
 10 the plan and which does not consist of coverage ex-
 11 cluded from the definition of health insurance cov-
 12 erage under subsection (c)(4)(B).

13 (4) TREATMENT OF CHURCH PLANS.—

14 (A) EXCLUSION.—The requirements of
 15 this title insofar as they apply to group health
 16 plans shall not apply to church plans.

17 (B) OPTIONAL DISREGARD IN DETERMIN-
 18 ING PERIOD OF COVERAGE.—For purposes of
 19 applying section 101(b)(3)(B)(i), a group health
 20 plan may elect to disregard periods of coverage
 21 of an individual under a church plan that, pur-
 22 suant to subparagraph (A), is not subject to the
 23 requirements of this title.

24 (5) TREATMENT OF GOVERNMENTAL PLANS.—

1 (A) ELECTION TO BE EXCLUDED.—If the
2 plan sponsor of a governmental plan which is a
3 group health plan to which the provisions of
4 this subtitle otherwise apply makes an election
5 under this paragraph for any specified period
6 (in such form and manner as the Secretary of
7 Health and Human Services may by regulations
8 prescribe), then the requirements of this title
9 insofar as they apply to group health plans
10 shall not apply to such governmental plans for
11 such period.

12 (B) OPTIONAL DISREGARD IN DETERMIN-
13 ING PERIOD OF COVERAGE IF ELECTION
14 MADE.—For purposes of applying section
15 101(b)(3)(B)(i), a group health plan may elect
16 to disregard periods of coverage of an individual
17 under a governmental plan that, under an elec-
18 tion under subparagraph (A), is not subject to
19 the requirements of this title.

20 (7) TREATMENT OF MEDICAID PLAN AS GROUP
21 HEALTH PLAN.—A State plan under title XIX of the
22 Social Security Act shall be treated as a group
23 health plan for purposes of applying section 101(c),
24 unless the State elects not to be so treated.

1 (8) TREATMENT OF MEDICARE AS GROUP
2 HEALTH PLAN.—Title XVIII of the Social Security
3 Act shall be treated as a group health plan for pur-
4 poses of applying section 101(c).

5 (b) INCORPORATION OF CERTAIN DEFINITIONS IN
6 EMPLOYEE RETIREMENT INCOME SECURITY ACT OF
7 1974.—Except as provided in this section, the terms “ben-
8 eficiary”, “church plan”, “employee”, “employee welfare
9 benefit plan”, “employer”, “governmental plan”, “multi-
10 employer plan”, “multiple employer welfare arrange-
11 ment”, “participant”, “plan sponsor”, and “State” have
12 the meanings given such terms in section 3 of the Em-
13 ployee Retirement Income Security Act of 1974.

14 (c) OTHER DEFINITIONS.—For purposes of this title:

15 (1) APPLICABLE STATE AUTHORITY.—The term
16 “applicable State authority” means, with respect to
17 an insurer or health maintenance organization in a
18 State, the State insurance commissioner or official
19 or officials designated by the State to enforce the re-
20 quirements of this title for the State involved with
21 respect to such insurer or organization.

22 (2) BONA FIDE ASSOCIATION.—The term “bona
23 fide association” means an association which—

24 (A) has been actively in existence for at
25 least 5 years,

1 (B) has been formed and maintained in
2 good faith for purposes other than obtaining in-
3 surance,

4 (C) does not condition membership in the
5 association on health status,

6 (D) makes health insurance coverage of-
7 fered through the association available to all
8 members regardless of health status,

9 (E) does not make health insurance cov-
10 erage offered through the association available
11 to any individual who is not a member (or de-
12 pendent of a member) of the association at the
13 time the coverage is initially issued,

14 (F) does not impose preexisting condition
15 exclusions except in a manner consistent with
16 the requirements of sections 101 and 102 as
17 they relate to group health plans, and

18 (G) provides for renewal and continuation
19 of health insurance coverage in a manner con-
20 sistent with the requirements of section 132 as
21 they relate to the renewal and continuation in
22 force of coverage in a group market.

23 (3) COBRA CONTINUATION PROVISION.—The
24 term “COBRA continuation provision” means any of
25 the following:

1 (A) Section 4980B of the Internal Revenue
2 Code of 1986, other than subsection (f)(1) of
3 such section insofar as it relates to pediatric
4 vaccines.

5 (B) Part 6 of subtitle B of title I of the
6 Employee Retirement Income Security Act of
7 1974 (29 U.S.C. 1161 et seq.), other than sec-
8 tion 609.

9 (C) Title XXII of the Public Health Serv-
10 ice Act.

11 (4) HEALTH INSURANCE COVERAGE.—

12 (A) IN GENERAL.—Except as provided in
13 subparagraph (B), the term “health insurance
14 coverage” means benefits consisting of medical
15 care (provided directly, through insurance or re-
16 imbursement, or otherwise) under any hospital
17 or medical service policy or certificate, hospital
18 or medical service plan contract, or health
19 maintenance organization group contract of-
20 fered by an insurer or a health maintenance or-
21 ganization.

22 (B) EXCEPTION.—Such term does not in-
23 clude coverage under any separate policy, cer-
24 tificate, or contract only for one or more of any
25 of the following:

1 (i) Coverage for accident, credit-only,
2 vision, disability income, long-term care,
3 nursing home care, community-based care
4 dental, on-site medical clinics, or employee
5 assistance programs, or any combination
6 thereof.

7 (ii) Medicare supplemental health in-
8 surance (within the meaning of section
9 1882(g)(1) of the Social Security Act (42
10 U.S.C. 1395ss(g)(1))) and similar supple-
11 mental coverage provided under a group
12 health plan.

13 (iii) Coverage issued as a supplement
14 to liability insurance.

15 (iv) Liability insurance, including gen-
16 eral liability insurance and automobile li-
17 ability insurance.

18 (v) Workers' compensation or similar
19 insurance.

20 (vi) Automobile medical-payment in-
21 surance.

22 (vii) Coverage consisting of benefit
23 payments made on a periodic basis for a
24 specified disease or illness or period of hos-
25 pitalization, without regard to the costs in-

1 curred or services rendered during the pe-
2 riod to which the payments relate.

3 (viii) Short-term limited duration in-
4 surance.

5 (ix) Such other coverage, comparable
6 to that described in previous clauses, as
7 may be specified in regulations prescribed
8 under this title.

9 (5) HEALTH MAINTENANCE ORGANIZATION;
10 HMO.—The terms “health maintenance organiza-
11 tion” and “HMO” mean—

12 (A) a Federally qualified health mainte-
13 nance organization (as defined in section
14 1301(a) of the Public Health Service Act (42
15 U.S.C. 300e(a))),

16 (B) an organization recognized under State
17 law as a health maintenance organization, or

18 (C) a similar organization regulated under
19 State law for solvency in the same manner and
20 to the same extent as such a health mainte-
21 nance organization,

22 if it is subject to State law which regulates insur-
23 ance (within the meaning of section 514(b)(2) of the
24 Employee Retirement Income Security Act of 1974).

1 (6) HEALTH STATUS.—The term “health sta-
2 tus” includes, with respect to an individual, medical
3 condition, claims experience, receipt of health care,
4 medical history, evidence of insurability, or disabil-
5 ity.

6 (7) INDIVIDUAL HEALTH INSURANCE COV-
7 ERAGE.—The term “individual health insurance cov-
8 erage” means health insurance coverage offered to
9 individuals if the coverage is not offered in connec-
10 tion with a group health plan (other than such a
11 plan that has fewer than two participants as current
12 employees on the first day of the plan year).

13 (8) INSURER.—The term “insurer” means an
14 insurance company, insurance service, or insurance
15 organization which is licensed to engage in the busi-
16 ness of insurance in a State and which is regulated
17 by a State (within the meaning of section
18 514(b)(2)(A) of the Employee Retirement Income
19 Security Act of 1974).

20 (9) MEDICAL CARE.—The term “medical care”
21 means—

22 (A) amounts paid for, or items or services
23 in the form of, the diagnosis, cure, mitigation,
24 treatment, or prevention of disease, or amounts
25 paid for, or items or services provided for, the

1 purpose of affecting any structure or function
2 of the body,

3 (B) amounts paid for, or services in the
4 form of, transportation primarily for and essen-
5 tial to medical care referred to in subparagraph
6 (A), and

7 (C) amounts paid for insurance covering
8 medical care referred to in subparagraphs (A)
9 and (B).

10 (10) NETWORK PLAN.—The term “network
11 plan” means, with respect to health insurance cov-
12 erage, an arrangement of an insurer or a health
13 maintenance organization under which the financing
14 and delivery of medical care are provided, in whole
15 or in part, through a defined set of providers under
16 contract with the insurer or health maintenance or-
17 ganization.

18 (11) WAITING PERIOD.—The term “waiting pe-
19 riod” means, with respect to a group health plan
20 and an individual who is a potential participant or
21 beneficiary in the plan, the minimum period that
22 must pass with respect to the individual before the
23 individual is eligible to be covered for benefits under
24 the plan.

25 (d) TREATMENT OF PARTNERSHIPS.—

1 (1) TREATMENT AS A GROUP HEALTH PLAN.—

2 Any plan, fund, or program which would not be (but
3 for this paragraph) an employee welfare benefit plan
4 and which is established or maintained by a partner-
5 ship, to the extent that such plan, fund, or program
6 provides medical care to present or former partners
7 in the partnership or to their dependents (as defined
8 under the terms of the plan, fund, or program), di-
9 rectly or through insurance, reimbursement, or oth-
10 erwise, shall be treated (subject to paragraph (1)) as
11 an employee welfare benefit plan which is a group
12 health plan.

13 (2) TREATMENT OF PARTNERSHIP AND PART-
14 NERS AND EMPLOYER AND PARTICIPANTS.—In the
15 case of a group health plan—

16 (A) the term “employer” includes the part-
17 nership in relation to any partner; and

18 (B) the term “participant” includes—

19 (i) in connection with a group health
20 plan maintained by a partnership, an indi-
21 vidual who is a partner in relation to the
22 partnership, or

23 (ii) in connection with a group health
24 plan maintained by a self-employed individ-
25 ual (under which one or more employees

1 are participants), the self-employed individ-
2 ual,
3 if such individual is or may become eligible to
4 receive a benefit under the plan or such individ-
5 ual's beneficiaries may be eligible to receive any
6 such benefit.

7 (e) DEFINITIONS RELATING TO MARKETS AND
8 SMALL EMPLOYERS.—As used in this title:

9 (1) INDIVIDUAL MARKET.—The term “individ-
10 ual market” means the market for health insurance
11 coverage offered to individuals and not to employers
12 or in connection with a group health plan and does
13 not include the market for such coverage issued only
14 by an insurer or HMO that makes such coverage
15 available only on the basis of affiliation with a bona
16 fide association (as defined in subsection (c)(2)).

17 (2) LARGE GROUP MARKET.—The term “large
18 group market” means the market for health insur-
19 ance coverage offered to employers (other than small
20 employers) on behalf of their employees (and their
21 dependents) and does not include health insurance
22 coverage available solely in connection with a bona
23 fide association (as defined in subsection (c)(2)).

24 (3) SMALL EMPLOYER.—The term “small em-
25 ployer” means, in connection with a group health

1 plan with respect to a calendar year, an employer
 2 who employs at least 2 but fewer than 51 employees
 3 on a typical business day in the year. All persons
 4 treated as a single employer under subsection (a) or
 5 (b) of section 52 shall be treated as a single em-
 6 ployer for purposes of this title.

7 (4) SMALL GROUP MARKET.—The term “small
 8 group market” means the health insurance market
 9 under which individuals obtain health insurance cov-
 10 erage (directly or through any arrangement) on be-
 11 half of themselves (and their dependents) on the
 12 basis of employment or other relationship with re-
 13 spect to a small employer and does not include
 14 health insurance coverage available solely in connec-
 15 tion with a bona fide association (as defined in sub-
 16 section (c)(2)).

17 **SEC. 192. STATE FLEXIBILITY TO PROVIDE GREATER PRO-**
 18 **TECTION.**

19 (a) STATE FLEXIBILITY TO PROVIDE GREATER PRO-
 20 TECTION.—Subject to subsection (b), nothing in this title
 21 shall be construed to preempt State laws that—

22 (1) require insurers or HMOs to impose a limi-
 23 tation or exclusion of benefits relating to the treat-
 24 ment of a preexisting condition for a period that is

1 shorter than the applicable period provided for under
2 this title; or

3 (2) allow individuals, participants, and bene-
4 ficiaries to be considered to be in a period of pre-
5 vious qualifying coverage if such individual, partici-
6 pant, or beneficiary experiences a lapse in coverage
7 that is greater than the 60-day periods provided for
8 under sections 101(b)(3)(A), 101(b)(3)(B)(ii), and
9 102(b)(2).

10 (b) NO OVERRIDE OF ERISA PREEMPTION.—Noth-
11 ing in this Act shall be construed to affect or modify the
12 provisions of section 514 of the Employee Retirement In-
13 come Security Act of 1974 (29 U.S.C. 1144).

14 **SEC. 193. EFFECTIVE DATE.**

15 (a) IN GENERAL.—Except as otherwise provided for
16 in this title, the provisions of this title shall apply with
17 respect to—

18 (1) group health plans, and health insurance
19 coverage offered in connection with group health
20 plans, for plan years beginning on or after January
21 1, 1998, and

22 (2) individual health insurance coverage issued,
23 renewed, in effect, or operated on or after July 1,
24 1998.

1 (b) CONSIDERATION OF PREVIOUS COVERAGE.—The
 2 Secretaries of Health and Human Services, Treasury, and
 3 Labor shall jointly establish rules regarding the treatment
 4 (in determining qualified coverage periods under sections
 5 102(b) and 141(b)) of coverage before the applicable effective date specified in subsection (a).

7 (c) TIMELY ISSUANCE OF REGULATIONS.—The Secretaries of Health and Human Services, the Treasury, and
 9 Labor shall issue such regulations on a timely basis as
 10 may be required to carry out this title.

11 **SEC. 194. RULE OF CONSTRUCTION.**

12 Nothing in this title or any amendment made thereby
 13 may be construed to require the coverage of any specific
 14 procedure, treatment, or service as part of a group health
 15 plan or health insurance coverage under this title or
 16 through regulation.

17 **TITLE II—PREVENTING HEALTH**
 18 **CARE FRAUD AND ABUSE; ADMINISTRATIVE SIMPLIFICATION**

21 **SEC. 200. REFERENCES IN TITLE.**

22 Except as otherwise specifically provided, whenever in
 23 this title an amendment is expressed in terms of an
 24 amendment to or repeal of a section or other provision,

1 the reference shall be considered to be made to that sec-
 2 tion or other provision of the Social Security Act.

3 **Subtitle A—Fraud and Abuse**
 4 **Control Program**

5 **SEC. 201. FRAUD AND ABUSE CONTROL PROGRAM.**

6 (a) ESTABLISHMENT OF PROGRAM.—Title XI (42
 7 U.S.C. 1301 et seq.) is amended by inserting after section
 8 1128B the following new section:

9 “FRAUD AND ABUSE CONTROL PROGRAM

10 “SEC. 1128C. (a) ESTABLISHMENT OF PROGRAM.—

11 “(1) IN GENERAL.—Not later than January 1,
 12 1997, the Secretary, acting through the Office of the
 13 Inspector General of the Department of Health and
 14 Human Services, and the Attorney General shall es-
 15 tablish a program—

16 “(A) to coordinate Federal, State, and
 17 local law enforcement programs to control fraud
 18 and abuse with respect to health plans,

19 “(B) to conduct investigations, audits,
 20 evaluations, and inspections relating to the de-
 21 livery of and payment for health care in the
 22 United States,

23 “(C) to facilitate the enforcement of the
 24 provisions of sections 1128, 1128A, and 1128B
 25 and other statutes applicable to health care
 26 fraud and abuse,

1 “(D) to provide for the modification and
2 establishment of safe harbors and to issue advi-
3 sory opinions and special fraud alerts pursuant
4 to section 1128D, and

5 “(E) to provide for the reporting and dis-
6 closure of certain final adverse actions against
7 health care providers, suppliers, or practitioners
8 pursuant to the data collection system estab-
9 lished under section 1128E.

10 “(2) COORDINATION WITH HEALTH PLANS.—In
11 carrying out the program established under para-
12 graph (1), the Secretary and the Attorney General
13 shall consult with, and arrange for the sharing of
14 data with representatives of health plans.

15 “(3) GUIDELINES.—

16 “(A) IN GENERAL.—The Secretary and the
17 Attorney General shall issue guidelines to carry
18 out the program under paragraph (1). The pro-
19 visions of sections 553, 556, and 557 of title 5,
20 United States Code, shall not apply in the issu-
21 ance of such guidelines.

22 “(B) INFORMATION GUIDELINES.—

23 “(i) IN GENERAL.—Such guidelines
24 shall include guidelines relating to the fur-
25 nishing of information by health plans,

1 providers, and others to enable the Sec-
2 retary and the Attorney General to carry
3 out the program (including coordination
4 with health plans under paragraph (2)).

5 “(ii) CONFIDENTIALITY.—Such guide-
6 lines shall include procedures to assure
7 that such information is provided and uti-
8 lized in a manner that appropriately pro-
9 tects the confidentiality of the information
10 and the privacy of individuals receiving
11 health care services and items.

12 “(iii) QUALIFIED IMMUNITY FOR PRO-
13 VIDING INFORMATION.—The provisions of
14 section 1157(a) (relating to limitation on
15 liability) shall apply to a person providing
16 information to the Secretary or the Attor-
17 ney General in conjunction with their per-
18 formance of duties under this section.

19 “(4) ENSURING ACCESS TO DOCUMENTATION.—
20 The Inspector General of the Department of Health
21 and Human Services is authorized to exercise such
22 authority described in paragraphs (3) through (9) of
23 section 6 of the Inspector General Act of 1978 (5
24 U.S.C. App.) as necessary with respect to the activi-

1 ties under the fraud and abuse control program es-
2 tablished under this subsection.

3 “(5) AUTHORITY OF INSPECTOR GENERAL.—
4 Nothing in this Act shall be construed to diminish
5 the authority of any Inspector General, including
6 such authority as provided in the Inspector General
7 Act of 1978 (5 U.S.C. App.).

8 “(b) ADDITIONAL USE OF FUNDS BY INSPECTOR
9 GENERAL.—

10 “(1) REIMBURSEMENTS FOR INVESTIGA-
11 TIONS.—The Inspector General of the Department
12 of Health and Human Services is authorized to re-
13 ceive and retain for current use reimbursement for
14 the costs of conducting investigations and audits and
15 for monitoring compliance plans when such costs are
16 ordered by a court, voluntarily agreed to by the
17 payor, or otherwise.

18 “(2) CREDITING.—Funds received by the In-
19 specter General under paragraph (1) as reimburse-
20 ment for costs of conducting investigations shall be
21 deposited to the credit of the appropriation from
22 which initially paid, or to appropriations for similar
23 purposes currently available at the time of deposit,
24 and shall remain available for obligation for 1 year
25 from the date of the deposit of such funds.

1 “(c) HEALTH PLAN DEFINED.—For purposes of this
 2 section, the term ‘health plan’ means a plan or program
 3 that provides health benefits, whether directly, through in-
 4 surance, or otherwise, and includes—

5 “(1) a policy of health insurance;

6 “(2) a contract of a service benefit organiza-
 7 tion; and

8 “(3) a membership agreement with a health
 9 maintenance organization or other prepaid health
 10 plan.”.

11 (b) ESTABLISHMENT OF HEALTH CARE FRAUD AND
 12 ABUSE CONTROL ACCOUNT IN FEDERAL HOSPITAL IN-
 13 SURANCE TRUST FUND.—Section 1817 (42 U.S.C. 1395i)
 14 is amended by adding at the end the following new sub-
 15 section:

16 “(k) HEALTH CARE FRAUD AND ABUSE CONTROL
 17 ACCOUNT.—

18 “(1) ESTABLISHMENT.—There is hereby estab-
 19 lished in the Trust Fund an expenditure account to
 20 be known as the ‘Health Care Fraud and Abuse
 21 Control Account’ (in this subsection referred to as
 22 the ‘Account’).

23 “(2) APPROPRIATED AMOUNTS TO TRUST
 24 FUND.—

1 “(A) IN GENERAL.—There are hereby ap-
2 propriated to the Trust Fund—

3 “(i) such gifts and bequests as may be
4 made as provided in subparagraph (B);

5 “(ii) such amounts as may be depos-
6 ited in the Trust Fund as provided in sec-
7 tions 242(b) and 249(c) of the Health Cov-
8 erage Availability and Affordability Act of
9 1996, and title XI; and

10 “(iii) such amounts as are transferred
11 to the Trust Fund under subparagraph
12 (C).

13 “(B) AUTHORIZATION TO ACCEPT GIFTS.—
14 The Trust Fund is authorized to accept on be-
15 half of the United States money gifts and be-
16 quests made unconditionally to the Trust Fund,
17 for the benefit of the Account or any activity fi-
18 nanced through the Account.

19 “(C) TRANSFER OF AMOUNTS.—The Man-
20 aging Trustee shall transfer to the Trust Fund,
21 under rules similar to the rules in section 9601
22 of the Internal Revenue Code of 1986, an
23 amount equal to the sum of the following:

24 “(i) Criminal fines recovered in cases
25 involving a Federal health care offense (as

1 defined in section 982(a)(6)(B) of title 18,
2 United States Code).

3 “(ii) Civil monetary penalties and as-
4 sessments imposed in health care cases, in-
5 cluding amounts recovered under titles XI,
6 XVIII, and XXI, and chapter 38 of title
7 31, United States Code (except as other-
8 wise provided by law).

9 “(iii) Amounts resulting from the for-
10 feiture of property by reason of a Federal
11 health care offense.

12 “(iv) Penalties and damages obtained
13 and otherwise creditable to miscellaneous
14 receipts of the general fund of the Treas-
15 ury obtained under sections 3729 through
16 3733 of title 31, United States Code
17 (known as the False Claims Act), in cases
18 involving claims related to the provision of
19 health care items and services (other than
20 funds awarded to a relator, for restitution
21 or otherwise authorized by law).

22 “(3) APPROPRIATED AMOUNTS TO ACCOUNT
23 FOR FRAUD AND ABUSE CONTROL PROGRAM, ETC.—

24 “(A) DEPARTMENTS OF HEALTH AND
25 HUMAN SERVICES AND JUSTICE.—

1 “(i) IN GENERAL.—There are hereby
2 appropriated to the Account from the
3 Trust Fund such sums as the Secretary
4 and the Attorney General certify are nec-
5 essary to carry out the purposes described
6 in subparagraph (C), to be available with-
7 out further appropriation, in an amount
8 not to exceed—

9 “(I) for fiscal year 1997,
10 \$104,000,000, and

11 “(II) for each of the fiscal years
12 1998 through 2003, the limit for the
13 preceding fiscal year, increased by 15
14 percent; and

15 “(III) for each fiscal year after
16 fiscal year 2003, the limit for fiscal
17 year 2003.

18 “(ii) MEDICARE AND MEDICAID AC-
19 TIVITIES.—For each fiscal year, of the
20 amount appropriated in clause (i), the fol-
21 lowing amounts shall be available only for
22 the purposes of the activities of the Office
23 of the Inspector General of the Depart-
24 ment of Health and Human Services with

1 respect to the medicare and medicaid pro-
2 grams—

3 “(I) for fiscal year 1997, not less
4 than \$60,000,000 and not more than
5 \$70,000,000;

6 “(II) for fiscal year 1998, not
7 less than \$80,000,000 and not more
8 than \$90,000,000;

9 “(III) for fiscal year 1999, not
10 less than \$90,000,000 and not more
11 than \$100,000,000;

12 “(IV) for fiscal year 2000, not
13 less than \$110,000,000 and not more
14 than \$120,000,000;

15 “(V) for fiscal year 2001, not
16 less than \$120,000,000 and not more
17 than \$130,000,000;

18 “(VI) for fiscal year 2002, not
19 less than \$140,000,000 and not more
20 than \$150,000,000; and

21 “(VII) for each fiscal year after
22 fiscal year 2002, not less than
23 \$150,000,000 and not more than
24 \$160,000,000.

1 “(B) FEDERAL BUREAU OF INVESTIGA-
2 TION.—There are hereby appropriated from the
3 general fund of the United States Treasury and
4 hereby appropriated to the Account for transfer
5 to the Federal Bureau of Investigation to carry
6 out the purposes described in subparagraph
7 (C), to be available without further appropria-
8 tion—

9 “(i) for fiscal year 1997, \$47,000,000;

10 “(ii) for fiscal year 1998,
11 \$56,000,000;

12 “(iii) for fiscal year 1999,
13 \$66,000,000;

14 “(iv) for fiscal year 2000,
15 \$76,000,000;

16 “(v) for fiscal year 2001,
17 \$88,000,000;

18 “(vi) for fiscal year 2002,
19 \$101,000,000; and

20 “(vii) for each fiscal year after fiscal
21 year 2002, \$114,000,000.

22 “(C) USE OF FUNDS.—The purposes de-
23 scribed in this subparagraph are to cover the
24 costs (including equipment, salaries and bene-
25 fits, and travel and training) of the administra-

tion and operation of the health care fraud and abuse control program established under section 1128C(a), including the costs of—

“(i) prosecuting health care matters (through criminal, civil, and administrative proceedings);

“(ii) investigations;

“(iii) financial and performance audits of health care programs and operations;

“(iv) inspections and other evaluations; and

“(v) provider and consumer education regarding compliance with the provisions of title XI.

“(4) APPROPRIATED AMOUNTS TO ACCOUNT FOR MEDICARE INTEGRITY PROGRAM.—

“(A) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund for each fiscal year such amounts as are necessary to carry out the Medicare Integrity Program under section 1893, subject to subparagraph (B) and to be available without further appropriation.

1 “(B) AMOUNTS SPECIFIED.—The amount
2 appropriated under subparagraph (A) for a fis-
3 cal year is as follows:

4 “(i) For fiscal year 1997, such
5 amount shall be not less than
6 \$430,000,000 and not more than
7 \$440,000,000.

8 “(ii) For fiscal year 1998, such
9 amount shall be not less than
10 \$490,000,000 and not more than
11 \$500,000,000.

12 “(iii) For fiscal year 1999, such
13 amount shall be not less than
14 \$550,000,000 and not more than
15 \$560,000,000.

16 “(iv) For fiscal year 2000, such
17 amount shall be not less than
18 \$620,000,000 and not more than
19 \$630,000,000.

20 “(v) For fiscal year 2001, such
21 amount shall be not less than
22 \$670,000,000 and not more than
23 \$680,000,000.

24 “(vi) For fiscal year 2002, such
25 amount shall be not less than

1 \$690,000,000 and not more than
2 \$700,000,000.

3 “(vii) For each fiscal year after fiscal
4 year 2002, such amount shall be not less
5 than \$710,000,000 and not more than
6 \$720,000,000.

7 “(5) ANNUAL REPORT.—The Secretary and the
8 Attorney General shall submit jointly an annual re-
9 port to Congress on the amount of revenue which is
10 generated and disbursed, and the justification for
11 such disbursements, by the Account in each fiscal
12 year.”.

13 **SEC. 202. MEDICARE INTEGRITY PROGRAM.**

14 (a) ESTABLISHMENT OF MEDICARE INTEGRITY PRO-
15 GRAM.—Title XVIII is amended by adding at the end the
16 following new section:

17 “MEDICARE INTEGRITY PROGRAM

18 “SEC. 1893. (a) ESTABLISHMENT OF PROGRAM.—
19 There is hereby established the Medicare Integrity Pro-
20 gram (in this section referred to as the ‘Program’) under
21 which the Secretary shall promote the integrity of the
22 medicare program by entering into contracts in accord-
23 ance with this section with eligible private entities to carry
24 out the activities described in subsection (b).

25 “(b) ACTIVITIES DESCRIBED.—The activities de-
26 scribed in this subsection are as follows:

1 “(1) Review of activities of providers of services
2 or other individuals and entities furnishing items
3 and services for which payment may be made under
4 this title (including skilled nursing facilities and
5 home health agencies), including medical and utiliza-
6 tion review and fraud review (employing similar
7 standards, processes, and technologies used by pri-
8 vate health plans, including equipment and software
9 technologies which surpass the capability of the
10 equipment and technologies used in the review of
11 claims under this title as of the date of the enact-
12 ment of this section).

13 “(2) Audit of cost reports.

14 “(3) Determinations as to whether payment
15 should not be, or should not have been, made under
16 this title by reason of section 1862(b), and recovery
17 of payments that should not have been made.

18 “(4) Education of providers of services, bene-
19 ficiaries, and other persons with respect to payment
20 integrity and benefit quality assurance issues.

21 “(5) Developing (and periodically updating) a
22 list of items of durable medical equipment in accord-
23 ance with section 1834(a)(15) which are subject to
24 prior authorization under such section.

1 “(c) ELIGIBILITY OF ENTITIES.—An entity is eligible
2 to enter into a contract under the Program to carry out
3 any of the activities described in subsection (b) if—

4 “(1) the entity has demonstrated capability to
5 carry out such activities;

6 “(2) in carrying out such activities, the entity
7 agrees to cooperate with the Inspector General of
8 the Department of Health and Human Services, the
9 Attorney General of the United States, and other
10 law enforcement agencies, as appropriate, in the in-
11 vestigation and deterrence of fraud and abuse in re-
12 lation to this title and in other cases arising out of
13 such activities;

14 “(3) the entity demonstrates to the Secretary
15 that the entity’s financial holdings, interests, or rela-
16 tionships will not interfere with its ability to perform
17 the functions to be required by the contract in an ef-
18 fective and impartial manner; and

19 “(4) the entity meets such other requirements
20 as the Secretary may impose.

21 In the case of the activity described in subsection (b)(5),
22 an entity shall be deemed to be eligible to enter into a
23 contract under the Program to carry out the activity if
24 the entity is a carrier with a contract in effect under sec-
25 tion 1842.

1 “(d) PROCESS FOR ENTERING INTO CONTRACTS.—

2 The Secretary shall enter into contracts under the Pro-
3 gram in accordance with such procedures as the Secretary
4 shall by regulation establish, except that such procedures
5 shall include the following:

6 “(1) The Secretary shall determine the appro-
7 appropriate number of separate contracts which are nec-
8 essary to carry out the Program and the appropriate
9 times at which the Secretary shall enter into such
10 contracts.

11 “(2)(A) Except as provided in subparagraph
12 (B), the provisions of section 1153(e)(1) shall apply
13 to contracts and contracting authority under this
14 section.

15 “(B) Competitive procedures must be used
16 when entering into new contracts under this section,
17 or at any other time considered appropriate by the
18 Secretary, except that the Secretary may contract
19 with entities that are carrying out the activities de-
20 scribed in this section pursuant to agreements under
21 section 1816 or contracts under section 1842 in ef-
22 fect on the date of the enactment of this section.

23 “(3) A contract under this section may be re-
24 newed without regard to any provision of law requir-
25 ing competition if the contractor has met or ex-

1 ceeded the performance requirements established in
2 the current contract.

3 “(e) LIMITATION ON CONTRACTOR LIABILITY.—The
4 Secretary shall by regulation provide for the limitation of
5 a contractor’s liability for actions taken to carry out a con-
6 tract under the Program, and such regulation shall, to the
7 extent the Secretary finds appropriate, employ the same
8 or comparable standards and other substantive and proce-
9 dural provisions as are contained in section 1157.”.

10 (b) ELIMINATION OF FI AND CARRIER RESPONSIBIL-
11 ITY FOR CARRYING OUT ACTIVITIES SUBJECT TO PRO-
12 GRAM.—

13 (1) RESPONSIBILITIES OF FISCAL
14 INTERMEDIARIES UNDER PART A.—Section 1816
15 (42 U.S.C. 1395h) is amended by adding at the end
16 the following new subsection:

17 “(l) No agency or organization may carry out (or re-
18 ceive payment for carrying out) any activity pursuant to
19 an agreement under this section to the extent that the ac-
20 tivity is carried out pursuant to a contract under the Med-
21 icare Integrity Program under section 1893.”.

22 (2) RESPONSIBILITIES OF CARRIERS UNDER
23 PART B.—Section 1842(c) (42 U.S.C. 1395u(c)) is
24 amended by adding at the end the following new
25 paragraph:

1 “(6) No carrier may carry out (or receive payment
2 for carrying out) any activity pursuant to a contract under
3 this subsection to the extent that the activity is carried
4 out pursuant to a contract under the Medicare Integrity
5 Program under section 1893. The previous sentence shall
6 not apply with respect to the activity described in section
7 1893(b)(5) (relating to prior authorization of certain
8 items of durable medical equipment under section
9 1834(a)(15)).”.

10 **SEC. 203. BENEFICIARY INCENTIVE PROGRAMS.**

11 (a) CLARIFICATION OF REQUIREMENT TO PROVIDE
12 EXPLANATION OF MEDICARE BENEFITS.—The Secretary
13 of Health and Human Services (in this section referred
14 to as the “Secretary”) shall provide an explanation of ben-
15 efits under the medicare program under title XVIII of the
16 Social Security Act with respect to each item or service
17 for which payment may be made under the program which
18 is furnished to an individual, without regard to whether
19 or not a deductible or coinsurance may be imposed against
20 the individual with respect to the item or service.

21 (b) PROGRAM TO COLLECT INFORMATION ON FRAUD
22 AND ABUSE.—

23 (1) ESTABLISHMENT OF PROGRAM.—Not later
24 than 3 months after the date of the enactment of
25 this Act, the Secretary shall establish a program

1 under which the Secretary shall encourage individ-
2 uals to report to the Secretary information on indi-
3 viduals and entities who are engaging or who have
4 engaged in acts or omissions which constitute
5 grounds for the imposition of a sanction under sec-
6 tion 1128, section 1128A, or section 1128B of the
7 Social Security Act, or who have otherwise engaged
8 in fraud and abuse against the medicare program
9 for which there is a sanction provided under law.
10 The program shall discourage provision of, and not
11 consider, information which is frivolous or otherwise
12 not relevant or material to the imposition of such a
13 sanction.

14 (2) PAYMENT OF PORTION OF AMOUNTS COL-
15 LECTED.—If an individual reports information to
16 the Secretary under the program established under
17 paragraph (1) which serves as the basis for the col-
18 lection by the Secretary or the Attorney General of
19 any amount of at least \$100 (other than any
20 amount paid as a penalty under section 1128B of
21 the Social Security Act), the Secretary may pay a
22 portion of the amount collected to the individual
23 (under procedures similar to those applicable under
24 section 7623 of the Internal Revenue Code of 1986

1 to payments to individuals providing information on
2 violations of such Code).

3 (c) PROGRAM TO COLLECT INFORMATION ON PRO-
4 GRAM EFFICIENCY.—

5 (1) ESTABLISHMENT OF PROGRAM.—Not later
6 than 3 months after the date of the enactment of
7 this Act, the Secretary shall establish a program
8 under which the Secretary shall encourage individ-
9 uals to submit to the Secretary suggestions on meth-
10 ods to improve the efficiency of the medicare pro-
11 gram.

12 (2) PAYMENT OF PORTION OF PROGRAM SAV-
13 INGS.—If an individual submits a suggestion to the
14 Secretary under the program established under
15 paragraph (1) which is adopted by the Secretary and
16 which results in savings to the program, the Sec-
17 retary may make a payment to the individual of
18 such amount as the Secretary considers appropriate.

19 **SEC. 204. APPLICATION OF CERTAIN HEALTH ANTI-FRAUD**
20 **AND ABUSE SANCTIONS TO FRAUD AND**
21 **ABUSE AGAINST FEDERAL HEALTH CARE**
22 **PROGRAMS.**

23 (a) IN GENERAL.—Section 1128B (42 U.S.C.
24 1320a-7b) is amended as follows:

1 (1) In the heading, by striking “MEDICARE OR
2 STATE HEALTH CARE PROGRAMS” and inserting
3 “FEDERAL HEALTH CARE PROGRAMS”.

4 (2) In subsection (a)(1), by striking “a program
5 under title XVIII or a State health care program (as
6 defined in section 1128(h))” and inserting “a Fed-
7 eral health care program”.

8 (3) In subsection (a)(5), by striking “a program
9 under title XVIII or a State health care program”
10 and inserting “a Federal health care program”.

11 (4) In the second sentence of subsection (a)—

12 (A) by striking “a State plan approved
13 under title XIX” and inserting “a Federal
14 health care program”, and

15 (B) by striking “the State may at its op-
16 tion (notwithstanding any other provision of
17 that title or of such plan)” and inserting “the
18 administrator of such program may at its op-
19 tion (notwithstanding any other provision of
20 such program)”.

21 (5) In subsection (b), by striking “title XVIII
22 or a State health care program” each place it ap-
23 pears and inserting “a Federal health care pro-
24 gram”.

1 (6) In subsection (c), by inserting “(as defined
2 in section 1128(h))” after “a State health care pro-
3 gram”.

4 (7) By adding at the end the following new sub-
5 section:

6 “(f) For purposes of this section, the term ‘Federal
7 health care program’ means—

8 “(1) any plan or program that provides health
9 benefits, whether directly, through insurance, or oth-
10 erwise, which is funded directly, in whole or in part,
11 by the United States Government (other than the
12 health insurance program under chapter 89 of title
13 5, United States Code); or

14 “(2) any State health care program, as defined
15 in section 1128(h).”.

16 (b) EFFECTIVE DATE.—The amendments made by
17 this section shall take effect on January 1, 1997.

18 **SEC. 205. GUIDANCE REGARDING APPLICATION OF HEALTH**
19 **CARE FRAUD AND ABUSE SANCTIONS.**

20 Title XI (42 U.S.C. 1301 et seq.), as amended by
21 section 201, is amended by inserting after section 1128C
22 the following new section:

1 “GUIDANCE REGARDING APPLICATION OF HEALTH CARE
2 FRAUD AND ABUSE SANCTIONS

3 “SEC. 1128D. (a) SOLICITATION AND PUBLICATION
4 OF MODIFICATIONS TO EXISTING SAFE HARBORS AND
5 NEW SAFE HARBORS.—

6 “(1) IN GENERAL.—

7 “(A) SOLICITATION OF PROPOSALS FOR
8 SAFE HARBORS.—Not later than January 1,
9 1997, and not less than annually thereafter, the
10 Secretary shall publish a notice in the Federal
11 Register soliciting proposals, which will be ac-
12 cepted during a 60-day period, for—

13 “(i) modifications to existing safe har-
14 bors issued pursuant to section 14(a) of
15 the Medicare and Medicaid Patient and
16 Program Protection Act of 1987 (42
17 U.S.C. 1320a–7b note);

18 “(ii) additional safe harbors specifying
19 payment practices that shall not be treated
20 as a criminal offense under section
21 1128B(b) and shall not serve as the basis
22 for an exclusion under section 1128(b)(7);

23 “(iii) advisory opinions to be issued
24 pursuant to subsection (b); and

1 “(iv) special fraud alerts to be issued
2 pursuant to subsection (c).

3 “(B) PUBLICATION OF PROPOSED MODI-
4 FICATIONS AND PROPOSED ADDITIONAL SAFE
5 HARBORS.—After considering the proposals de-
6 scribed in clauses (i) and (ii) of subparagraph
7 (A), the Secretary, in consultation with the At-
8 torney General, shall publish in the Federal
9 Register proposed modifications to existing safe
10 harbors and proposed additional safe harbors, if
11 appropriate, with a 60-day comment period.
12 After considering any public comments received
13 during this period, the Secretary shall issue
14 final rules modifying the existing safe harbors
15 and establishing new safe harbors, as appro-
16 priate.

17 “(C) REPORT.—The Inspector General of
18 the Department of Health and Human Services
19 (in this section referred to as the ‘Inspector
20 General’) shall, in an annual report to Congress
21 or as part of the year-end semiannual report re-
22 quired by section 5 of the Inspector General
23 Act of 1978 (5 U.S.C. App.), describe the pro-
24 posals received under clauses (i) and (ii) of sub-
25 paragraph (A) and explain which proposals

1 were included in the publication described in
2 subparagraph (B), which proposals were not in-
3 cluded in that publication, and the reasons for
4 the rejection of the proposals that were not in-
5 cluded.

6 “(2) CRITERIA FOR MODIFYING AND ESTAB-
7 LISHING SAFE HARBORS.—In modifying and estab-
8 lishing safe harbors under paragraph (1)(B), the
9 Secretary may consider the extent to which provid-
10 ing a safe harbor for the specified payment practice
11 may result in any of the following:

12 “(A) An increase or decrease in access to
13 health care services.

14 “(B) An increase or decrease in the quality
15 of health care services.

16 “(C) An increase or decrease in patient
17 freedom of choice among health care providers.

18 “(D) An increase or decrease in competi-
19 tion among health care providers.

20 “(E) An increase or decrease in the ability
21 of health care facilities to provide services in
22 medically underserved areas or to medically un-
23 derserved populations.

1 “(F) An increase or decrease in the cost to
2 Federal health care programs (as defined in
3 section 1128B(f)).

4 “(G) An increase or decrease in the poten-
5 tial overutilization of health care services.

6 “(H) The existence or nonexistence of any
7 potential financial benefit to a health care pro-
8 fessional or provider which may vary based on
9 their decisions of—

10 “(i) whether to order a health care
11 item or service; or

12 “(ii) whether to arrange for a referral
13 of health care items or services to a par-
14 ticular practitioner or provider.

15 “(I) Any other factors the Secretary deems
16 appropriate in the interest of preventing fraud
17 and abuse in Federal health care programs (as
18 so defined).

19 “(b) ADVISORY OPINIONS.—

20 “(1) ISSUANCE OF ADVISORY OPINIONS.—The
21 Secretary shall issue written advisory opinions as
22 provided in this subsection.

23 “(2) MATTERS SUBJECT TO ADVISORY OPIN-
24 IONS.—The Secretary shall issue advisory opinions
25 as to the following matters:

1 “(A) What constitutes prohibited remuneration within the meaning of section 1128B(b).

4 “(B) Whether an arrangement or proposed arrangement satisfies the criteria set forth in section 1128B(b)(3) for activities which do not result in prohibited remuneration.

8 “(C) Whether an arrangement or proposed arrangement satisfies the criteria which the Secretary has established, or shall establish by regulation for activities which do not result in prohibited remuneration.

13 “(D) What constitutes an inducement to reduce or limit services to individuals entitled to benefits under title XVIII or title XIX or title XXI within the meaning of section 1128B(b).

17 “(E) Whether any activity or proposed activity constitutes grounds for the imposition of a sanction under section 1128, 1128A, or 1128B.

21 “(3) MATTERS NOT SUBJECT TO ADVISORY
22 OPINIONS.—Such advisory opinions shall not address
23 the following matters:

1 “(A) Whether the fair market value shall
2 be, or was paid or received for any goods, serv-
3 ices or property.

4 “(B) Whether an individual is a bona fide
5 employee within the requirements of section
6 3121(d)(2) of the Internal Revenue Code of
7 1986.

8 “(4) EFFECT OF ADVISORY OPINIONS.—

9 “(A) BINDING AS TO SECRETARY AND
10 PARTIES INVOLVED.—Each advisory opinion is-
11 sued by the Secretary shall be binding as to the
12 Secretary and the party or parties requesting
13 the opinion.

14 “(B) FAILURE TO SEEK OPINION.—The
15 failure of a party to seek an advisory opinion
16 may not be introduced into evidence to prove
17 that the party intended to violate the provisions
18 of sections 1128, 1128A, or 1128B.

19 “(5) REGULATIONS.—

20 “(A) IN GENERAL.—Not later than 180
21 days after the date of the enactment of this sec-
22 tion, the Secretary shall issue regulations to
23 carry out this section. Such regulations shall
24 provide for—

1 “(i) the procedure to be followed by a
2 party applying for an advisory opinion;

3 “(ii) the procedure to be followed by
4 the Secretary in responding to a request
5 for an advisory opinion;

6 “(iii) the interval in which the Sec-
7 retary shall respond;

8 “(iv) the reasonable fee to be charged
9 to the party requesting an advisory opin-
10 ion; and

11 “(v) the manner in which advisory
12 opinions will be made available to the pub-
13 lic.

14 “(B) SPECIFIC CONTENTS.—Under the
15 regulations promulgated pursuant to subpara-
16 graph (A)—

17 “(i) the Secretary shall be required to
18 respond to a party requesting an advisory
19 opinion by not later than 30 days after the
20 request is received; and

21 “(ii) the fee charged to the party re-
22 questing an advisory opinion shall be equal
23 to the costs incurred by the Secretary in
24 responding to the request.

25 “(c) SPECIAL FRAUD ALERTS.—

1 “(1) IN GENERAL.—

2 “(A) REQUEST FOR SPECIAL FRAUD
3 ALERTS.—Any person may present, at any
4 time, a request to the Inspector General for a
5 notice which informs the public of practices
6 which the Inspector General considers to be
7 suspect or of particular concern under the med-
8 icare program or a State health care program,
9 as defined in section 1128(h) (in this subsection
10 referred to as a ‘special fraud alert’).

11 “(B) ISSUANCE AND PUBLICATION OF SPE-
12 CIAL FRAUD ALERTS.—Upon receipt of a re-
13 quest described in subparagraph (A), the In-
14 spector General shall investigate the subject
15 matter of the request to determine whether a
16 special fraud alert should be issued. If appro-
17 priate, the Inspector General shall issue a spe-
18 cial fraud alert in response to the request. All
19 special fraud alerts issued pursuant to this sub-
20 paragraph shall be published in the Federal
21 Register.

22 “(2) CRITERIA FOR SPECIAL FRAUD ALERTS.—
23 In determining whether to issue a special fraud alert
24 upon a request described in paragraph (1), the In-
25 spector General may consider—

1 “(A) whether and to what extent the prac-
 2 tices that would be identified in the special
 3 fraud alert may result in any of the con-
 4 sequences described in subsection (a)(2); and

5 “(B) the volume and frequency of the con-
 6 duct that would be identified in the special
 7 fraud alert.”.

8 **Subtitle B—Revisions to Current** 9 **Sanctions for Fraud and Abuse**

10 **SEC. 211. MANDATORY EXCLUSION FROM PARTICIPATION**

11 **IN MEDICARE AND STATE HEALTH CARE PRO-** 12 **GRAMS.**

13 (a) INDIVIDUAL CONVICTED OF FELONY RELATING
 14 TO HEALTH CARE FRAUD.—

15 (1) IN GENERAL.—Section 1128(a) (42 U.S.C.
 16 1320a–7(a)) is amended by adding at the end the
 17 following new paragraph:

18 “(3) FELONY CONVICTION RELATING TO
 19 HEALTH CARE FRAUD.—Any individual or entity
 20 that has been convicted after the date of the enact-
 21 ment of the Health Coverage Availability and Af-
 22 fordability Act of 1996, under Federal or State law,
 23 in connection with the delivery of a health care item
 24 or service or with respect to any act or omission in
 25 a health care program (other than those specifically

1 described in paragraph (1)) operated by or financed
2 in whole or in part by any Federal, State, or local
3 government agency, of a criminal offense consisting
4 of a felony relating to fraud, theft, embezzlement,
5 breach of fiduciary responsibility, or other financial
6 misconduct.”.

7 (2) CONFORMING AMENDMENT.—Paragraph (1)
8 of section 1128(b) (42 U.S.C. 1320a–7(b)) is
9 amended to read as follows:

10 “(1) CONVICTION RELATING TO FRAUD.—Any
11 individual or entity that has been convicted after the
12 date of the enactment of the Health Coverage Avail-
13 ability and Affordability Act of 1996, under Federal
14 or State law—

15 “(A) of a criminal offense consisting of a
16 misdemeanor relating to fraud, theft, embezzle-
17 ment, breach of fiduciary responsibility, or
18 other financial misconduct—

19 “(i) in connection with the delivery of
20 a health care item or service, or

21 “(ii) with respect to any act or omis-
22 sion in a health care program (other than
23 those specifically described in subsection
24 (a)(1)) operated by or financed in whole or

1 in part by any Federal, State, or local gov-
2 ernment agency; or

3 “(B) of a criminal offense relating to
4 fraud, theft, embezzlement, breach of fiduciary
5 responsibility, or other financial misconduct
6 with respect to any act or omission in a pro-
7 gram (other than a health care program) oper-
8 ated by or financed in whole or in part by any
9 Federal, State, or local government agency.”.

10 (b) INDIVIDUAL CONVICTED OF FELONY RELATING
11 TO CONTROLLED SUBSTANCE.—

12 (1) IN GENERAL.—Section 1128(a) (42 U.S.C.
13 1320a–7(a)), as amended by subsection (a), is
14 amended by adding at the end the following new
15 paragraph:

16 “(4) FELONY CONVICTION RELATING TO CON-
17 TROLLED SUBSTANCE.—Any individual or entity
18 that has been convicted after the date of the enact-
19 ment of the Health Coverage Availability and Af-
20 fordability Act of 1996, under Federal or State law,
21 of a criminal offense consisting of a felony relating
22 to the unlawful manufacture, distribution, prescrip-
23 tion, or dispensing of a controlled substance.”.

24 (2) CONFORMING AMENDMENT.—Section
25 1128(b)(3) (42 U.S.C. 1320a–7(b)(3)) is amended—

1 (A) in the heading, by striking “CONVIC-
 2 TION” and inserting “MISDEMEANOR CONVIC-
 3 TION”; and

4 (B) by striking “criminal offense” and in-
 5 serting “criminal offense consisting of a mis-
 6 demeanor”.

7 **SEC. 212. ESTABLISHMENT OF MINIMUM PERIOD OF EX-**
 8 **CLUSION FOR CERTAIN INDIVIDUALS AND**
 9 **ENTITIES SUBJECT TO PERMISSIVE EXCLU-**
 10 **SION FROM MEDICARE AND STATE HEALTH**
 11 **CARE PROGRAMS.**

12 Section 1128(c)(3) (42 U.S.C. 1320a–7(c)(3)) is
 13 amended by adding at the end the following new subpara-
 14 graphs:

15 “(D) In the case of an exclusion of an individual or
 16 entity under paragraph (1), (2), or (3) of subsection (b),
 17 the period of the exclusion shall be 3 years, unless the
 18 Secretary determines in accordance with published regula-
 19 tions that a shorter period is appropriate because of miti-
 20 gating circumstances or that a longer period is appro-
 21 priate because of aggravating circumstances.

22 “(E) In the case of an exclusion of an individual or
 23 entity under subsection (b)(4) or (b)(5), the period of the
 24 exclusion shall not be less than the period during which
 25 the individual’s or entity’s license to provide health care

1 is revoked, suspended, or surrendered, or the individual
 2 or the entity is excluded or suspended from a Federal or
 3 State health care program.

4 “(F) In the case of an exclusion of an individual or
 5 entity under subsection (b)(6)(B), the period of the exclu-
 6 sion shall be not less than 1 year.”.

7 **SEC. 213. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH**
 8 **OWNERSHIP OR CONTROL INTEREST IN**
 9 **SANCTIONED ENTITIES.**

10 Section 1128(b) (42 U.S.C. 1320a–7(b)) is amended
 11 by adding at the end the following new paragraph:

12 “(15) INDIVIDUALS CONTROLLING A SANC-
 13 TIONED ENTITY.—(A) Any individual—

14 “(i) who has a direct or indirect ownership
 15 or control interest in a sanctioned entity and
 16 who knows or should know (as defined in sec-
 17 tion 1128A(i)(6)) of the action constituting the
 18 basis for the conviction or exclusion described
 19 in subparagraph (B); or

20 “(ii) who is an officer or managing em-
 21 ployee (as defined in section 1126(b)) of such
 22 an entity.

23 “(B) For purposes of subparagraph (A), the
 24 term ‘sanctioned entity’ means an entity—

1 “(i) that has been convicted of any offense
 2 described in subsection (a) or in paragraph (1),
 3 (2), or (3) of this subsection; or

4 “(ii) that has been excluded from partici-
 5 pation under a program under title XVIII or
 6 under a State health care program.”.

7 **SEC. 214. SANCTIONS AGAINST PRACTITIONERS AND PER-**
 8 **SONS FOR FAILURE TO COMPLY WITH STATU-**
 9 **TORY OBLIGATIONS.**

10 (a) MINIMUM PERIOD OF EXCLUSION FOR PRACTI-
 11 TIONERS AND PERSONS FAILING TO MEET STATUTORY
 12 OBLIGATIONS.—

13 (1) IN GENERAL.—The second sentence of sec-
 14 tion 1156(b)(1) (42 U.S.C. 1320c–5(b)(1)) is
 15 amended by striking “may prescribe)” and inserting
 16 “may prescribe, except that such period may not be
 17 less than 1 year)”.

18 (2) CONFORMING AMENDMENT.—Section
 19 1156(b)(2) (42 U.S.C. 1320c–5(b)(2)) is amended
 20 by striking “shall remain” and inserting “shall (sub-
 21 ject to the minimum period specified in the second
 22 sentence of paragraph (1)) remain”.

23 (b) REPEAL OF “UNWILLING OR UNABLE” CONDI-
 24 TION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1)
 25 (42 U.S.C. 1320c–5(b)(1)) is amended—

1 (1) in the second sentence, by striking “and de-
 2 termines” and all that follows through “such obliga-
 3 tions,”; and

4 (2) by striking the third sentence.

5 **SEC. 215. INTERMEDIATE SANCTIONS FOR MEDICARE**
 6 **HEALTH MAINTENANCE ORGANIZATIONS.**

7 (a) APPLICATION OF INTERMEDIATE SANCTIONS FOR
 8 ANY PROGRAM VIOLATIONS.—

9 (1) IN GENERAL.—Section 1876(i)(1) (42
 10 U.S.C. 1395mm(i)(1)) is amended by striking “the
 11 Secretary may terminate” and all that follows and
 12 inserting “in accordance with procedures established
 13 under paragraph (9), the Secretary may at any time
 14 terminate any such contract or may impose the in-
 15 termediate sanctions described in paragraph (6)(B)
 16 or (6)(C) (whichever is applicable) on the eligible or-
 17 ganization if the Secretary determines that the orga-
 18 nization—

19 “(A) has failed substantially to carry out
 20 the contract;

21 “(B) is carrying out the contract in a man-
 22 ner substantially inconsistent with the efficient
 23 and effective administration of this section; or

1 “(C) no longer substantially meets the ap-
2 plicable conditions of subsections (b), (c), (e),
3 and (f).”.

4 (2) OTHER INTERMEDIATE SANCTIONS FOR
5 MISCELLANEOUS PROGRAM VIOLATIONS.—Section
6 1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is amended by
7 adding at the end the following new subparagraph:
8 “(C) In the case of an eligible organization for which
9 the Secretary makes a determination under paragraph (1)
10 the basis of which is not described in subparagraph (A),
11 the Secretary may apply the following intermediate sanc-
12 tions:

13 “(i) Civil money penalties of not more than
14 \$25,000 for each determination under paragraph (1)
15 if the deficiency that is the basis of the determina-
16 tion has directly adversely affected (or has the sub-
17 stantial likelihood of adversely affecting) an individ-
18 ual covered under the organization’s contract.

19 “(ii) Civil money penalties of not more than
20 \$10,000 for each week beginning after the initiation
21 of procedures by the Secretary under paragraph (9)
22 during which the deficiency that is the basis of a de-
23 termination under paragraph (1) exists.

24 “(iii) Suspension of enrollment of individuals
25 under this section after the date the Secretary noti-

1 fies the organization of a determination under para-
2 graph (1) and until the Secretary is satisfied that
3 the deficiency that is the basis for the determination
4 has been corrected and is not likely to recur.”.

5 (3) PROCEDURES FOR IMPOSING SANCTIONS.—

6 Section 1876(i) (42 U.S.C. 1395mm(i)) is amended
7 by adding at the end the following new paragraph:
8 “(9) The Secretary may terminate a contract with an
9 eligible organization under this section or may impose the
10 intermediate sanctions described in paragraph (6) on the
11 organization in accordance with formal investigation and
12 compliance procedures established by the Secretary under
13 which—

14 “(A) the Secretary first provides the organiza-
15 tion with the reasonable opportunity to develop and
16 implement a corrective action plan to correct the de-
17 ficiencies that were the basis of the Secretary’s de-
18 termination under paragraph (1) and the organiza-
19 tion fails to develop or implement such a plan;

20 “(B) in deciding whether to impose sanctions,
21 the Secretary considers aggravating factors such as
22 whether an organization has a history of deficiencies
23 or has not taken action to correct deficiencies the
24 Secretary has brought to the organization’s atten-
25 tion;

1 “(C) there are no unreasonable or unnecessary
2 delays between the finding of a deficiency and the
3 imposition of sanctions; and

4 “(D) the Secretary provides the organization
5 with reasonable notice and opportunity for hearing
6 (including the right to appeal an initial decision) be-
7 fore imposing any sanction or terminating the con-
8 tract.”.

9 (4) CONFORMING AMENDMENTS.—Section
10 1876(i)(6)(B) (42 U.S.C. 1395mm(i)(6)(B)) is
11 amended by striking the second sentence.

12 (b) AGREEMENTS WITH PEER REVIEW ORGANIZA-
13 TIONS.—Section 1876(i)(7)(A) (42 U.S.C.
14 1395mm(i)(7)(A)) is amended by striking “an agreement”
15 and inserting “a written agreement”.

16 (c) EFFECTIVE DATE.—The amendments made by
17 this section shall apply with respect to contract years be-
18 ginning on or after January 1, 1996.

19 **SEC. 216. ADDITIONAL EXCEPTION TO ANTI-KICKBACK PEN-**
20 **ALTIES FOR DISCOUNTING AND MANAGED**
21 **CARE ARRANGEMENTS.**

22 (a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C.
23 1320a–7b(b)(3)) is amended—

24 (1) by striking “and” at the end of subpara-
25 graph (D);

1 (2) by striking the period at the end of sub-
2 paragraph (E) and inserting “; and”; and

3 (3) by adding at the end the following new sub-
4 paragraph:

5 “(F) any remuneration between an organization
6 and an individual or entity providing items or serv-
7 ices, or a combination thereof, pursuant to a written
8 agreement between the organization and the individ-
9 ual or entity if the organization is an eligible organi-
10 zation under section 1876 or if the written agree-
11 ment places the individual or entity at substantial fi-
12 nancial risk for the cost or utilization of the items
13 or services, or a combination thereof, which the indi-
14 vidual or entity is obligated to provide, whether
15 through a withhold, capitation, incentive pool, per
16 diem payment, or any other similar risk arrange-
17 ment which places the individual or entity at sub-
18 stantial financial risk.”.

19 (b) EFFECTIVE DATE.—The amendments made by
20 this section shall apply to written agreements entered into
21 on or after January 1, 1997.

1 **SEC. 217. CRIMINAL PENALTY FOR FRAUDULENT DISPOSI-**
2 **TION OF ASSETS IN ORDER TO OBTAIN MED-**
3 **ICAID BENEFITS.**

4 Section 1128B(a) (42 U.S.C. 1320a-7b(a)) is
5 amended—

6 (1) by striking “or” at the end of paragraph
7 (4);

8 (2) by adding “or” at the end of paragraph (5);
9 and

10 (3) by inserting after paragraph (5) the follow-
11 ing new paragraph:

12 “(6) knowingly and willfully disposes of assets
13 (including by any transfer in trust) in order for an
14 individual to become eligible for medical assistance
15 under a State plan under title XIX, if disposing of
16 the assets results in the imposition of a period of in-
17 eligibility for such assistance under section
18 1917(c),”.

19 **SEC. 218. EFFECTIVE DATE.**

20 Except as otherwise provided, the amendments made
21 by this subtitle shall take effect January 1, 1997.

Subtitle C—Data Collection

SEC. 221. ESTABLISHMENT OF THE HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM.

(a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.), as amended by sections 211 and 215, is amended by inserting after section 1128D the following new section:

“HEALTH CARE FRAUD AND ABUSE DATA COLLECTION
PROGRAM

“SEC. 1128E. (a) GENERAL PURPOSE.—Not later than January 1, 1997, the Secretary shall establish a national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (c).

“(b) REPORTING OF INFORMATION.—

“(1) IN GENERAL.—Each Government agency and health plan shall report any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier, or practitioner.

“(2) INFORMATION TO BE REPORTED.—The information to be reported under paragraph (1) includes:

1 “(A) The name and TIN (as defined in
2 section 7701(a)(41) of the Internal Revenue
3 Code of 1986) of any health care provider, sup-
4 plier, or practitioner who is the subject of a
5 final adverse action.

6 “(B) The name (if known) of any health
7 care entity with which a health care provider,
8 supplier, or practitioner is affiliated or associ-
9 ated.

10 “(C) The nature of the final adverse action
11 and whether such action is on appeal.

12 “(D) A description of the acts or omissions
13 and injuries upon which the final adverse action
14 was based, and such other information as the
15 Secretary determines by regulation is required
16 for appropriate interpretation of information re-
17 ported under this section.

18 “(3) CONFIDENTIALITY.—In determining what
19 information is required, the Secretary shall include
20 procedures to assure that the privacy of individuals
21 receiving health care services is appropriately pro-
22 tected.

23 “(4) TIMING AND FORM OF REPORTING.—The
24 information required to be reported under this sub-
25 section shall be reported regularly (but not less often

1 than monthly) and in such form and manner as the
2 Secretary prescribes. Such information shall first be
3 required to be reported on a date specified by the
4 Secretary.

5 “(5) TO WHOM REPORTED.—The information
6 required to be reported under this subsection shall
7 be reported to the Secretary.

8 “(c) DISCLOSURE AND CORRECTION OF INFORMA-
9 TION.—

10 “(1) DISCLOSURE.—With respect to the infor-
11 mation about final adverse actions (not including
12 settlements in which no findings of liability have
13 been made) reported to the Secretary under this sec-
14 tion respecting a health care provider, supplier, or
15 practitioner, the Secretary shall, by regulation, pro-
16 vide for—

17 “(A) disclosure of the information, upon
18 request, to the health care provider, supplier, or
19 licensed practitioner, and

20 “(B) procedures in the case of disputed ac-
21 curacy of the information.

22 “(2) CORRECTIONS.—Each Government agency
23 and health plan shall report corrections of informa-
24 tion already reported about any final adverse action
25 taken against a health care provider, supplier, or

1 practitioner, in such form and manner that the Sec-
2 retary prescribes by regulation.

3 “(d) ACCESS TO REPORTED INFORMATION.—

4 “(1) AVAILABILITY.—The information in this
5 database shall be available to Federal and State gov-
6 ernment agencies and health plans pursuant to pro-
7 cedures that the Secretary shall provide by regula-
8 tion.

9 “(2) FEES FOR DISCLOSURE.—The Secretary
10 may establish or approve reasonable fees for the dis-
11 closure of information in this database (other than
12 with respect to requests by Federal agencies). The
13 amount of such a fee shall be sufficient to recover
14 the full costs of operating the database. Such fees
15 shall be available to the Secretary or, in the Sec-
16 retary’s discretion to the agency designated under
17 this section to cover such costs.

18 “(e) PROTECTION FROM LIABILITY FOR REPORT-
19 ING.—No person or entity, including the agency des-
20 ignated by the Secretary in subsection (b)(5) shall be held
21 liable in any civil action with respect to any report made
22 as required by this section, without knowledge of the fal-
23 sity of the information contained in the report.

24 “(f) DEFINITIONS AND SPECIAL RULES.—For pur-
25 poses of this section:

1 “(1) FINAL ADVERSE ACTION.—

2 “(A) IN GENERAL.—The term ‘final ad-
3 verse action’ includes:

4 “(i) Civil judgments against a health
5 care provider, supplier, or practitioner in
6 Federal or State court related to the deliv-
7 ery of a health care item or service.

8 “(ii) Federal or State criminal convic-
9 tions related to the delivery of a health
10 care item or service.

11 “(iii) Actions by Federal or State
12 agencies responsible for the licensing and
13 certification of health care providers, sup-
14 pliers, and licensed health care practition-
15 ers, including—

16 “(I) formal or official actions,
17 such as revocation or suspension of a
18 license (and the length of any such
19 suspension), reprimand, censure or
20 probation,

21 “(II) any other loss of license or
22 the right to apply for, or renew, a li-
23 cense of the provider, supplier, or
24 practitioner, whether by operation of

1 law, voluntary surrender, non-renew-
2 ability, or otherwise, or

3 “(III) any other negative action
4 or finding by such Federal or State
5 agency that is publicly available infor-
6 mation.

7 “(iv) Exclusion from participation in
8 Federal or State health care programs.

9 “(v) Any other adjudicated actions or
10 decisions that the Secretary shall establish
11 by regulation.

12 “(B) EXCEPTION.—The term does not in-
13 clude any action with respect to a malpractice
14 claim.

15 “(2) PRACTITIONER.—The terms ‘licensed
16 health care practitioner’, ‘licensed practitioner’, and
17 ‘practitioner’ mean, with respect to a State, an indi-
18 vidual who is licensed or otherwise authorized by the
19 State to provide health care services (or any individ-
20 ual who, without authority holds himself or herself
21 out to be so licensed or authorized).

22 “(3) GOVERNMENT AGENCY.—The term ‘Gov-
23 ernment agency’ shall include:

24 “(A) The Department of Justice.

1 “(B) The Department of Health and
2 Human Services.

3 “(C) Any other Federal agency that either
4 administers or provides payment for the deliv-
5 ery of health care services, including, but not
6 limited to the Department of Defense and the
7 Veterans’ Administration.

8 “(D) State law enforcement agencies.

9 “(E) State medicaid fraud control units.

10 “(F) Federal or State agencies responsible
11 for the licensing and certification of health care
12 providers and licensed health care practitioners.

13 “(4) HEALTH PLAN.—The term ‘health plan’
14 has the meaning given such term by section
15 1128C(c).

16 “(5) DETERMINATION OF CONVICTION.—For
17 purposes of paragraph (1), the existence of a convic-
18 tion shall be determined under paragraph (4) of sec-
19 tion 1128(i).”.

20 (b) IMPROVED PREVENTION IN ISSUANCE OF MEDI-
21 CARE PROVIDER NUMBERS.—Section 1842(r) (42 U.S.C.
22 1395u(r)) is amended by adding at the end the following
23 new sentence: “Under such system, the Secretary may im-
24 pose appropriate fees on such physicians to cover the costs

1 of investigation and recertification activities with respect
 2 to the issuance of the identifiers.”.

3 **Subtitle D—Civil Monetary** 4 **Penalties**

5 **SEC. 231. SOCIAL SECURITY ACT CIVIL MONETARY PEN-** 6 **ALTIES.**

7 (a) GENERAL CIVIL MONETARY PENALTIES.—Sec-
 8 tion 1128A (42 U.S.C. 1320a–7a) is amended as follows:

9 (1) In the third sentence of subsection (a), by
 10 striking “programs under title XVIII” and inserting
 11 “Federal health care programs (as defined in section
 12 1128B(f)(1))”.

13 (2) In subsection (f)—

14 (A) by redesignating paragraph (3) as
 15 paragraph (4); and

16 (B) by inserting after paragraph (2) the
 17 following new paragraph:

18 “(3) With respect to amounts recovered arising
 19 out of a claim under a Federal health care program
 20 (as defined in section 1128B(f)), the portion of such
 21 amounts as is determined to have been paid by the
 22 program shall be repaid to the program, and the
 23 portion of such amounts attributable to the amounts
 24 recovered under this section by reason of the amend-
 25 ments made by the Health Coverage Availability and

1 Affordability Act of 1996 (as estimated by the Sec-
2 retary) shall be deposited into the Federal Hospital
3 Insurance Trust Fund pursuant to section
4 1817(k)(2)(C).”.

5 (3) In subsection (i)—

6 (A) in paragraph (2), by striking “title V,
7 XVIII, XIX, or XX of this Act” and inserting
8 “a Federal health care program (as defined in
9 section 1128B(f))”,

10 (B) in paragraph (4), by striking “a health
11 insurance or medical services program under
12 title XVIII or XIX of this Act” and inserting
13 “a Federal health care program (as so de-
14 fined)”, and

15 (C) in paragraph (5), by striking “title V,
16 XVIII, XIX, or XX” and inserting “a Federal
17 health care program (as so defined)”.

18 (4) By adding at the end the following new sub-
19 section:

20 “(m)(1) For purposes of this section, with respect to
21 a Federal health care program not contained in this Act,
22 references to the Secretary in this section shall be deemed
23 to be references to the Secretary or Administrator of the
24 department or agency with jurisdiction over such program
25 and references to the Inspector General of the Department

1 of Health and Human Services in this section shall be
2 deemed to be references to the Inspector General of the
3 applicable department or agency.

4 “(2)(A) The Secretary and Administrator of the de-
5 partments and agencies referred to in paragraph (1) may
6 include in any action pursuant to this section, claims with-
7 in the jurisdiction of other Federal departments or agen-
8 cies as long as the following conditions are satisfied:

9 “(i) The case involves primarily claims submit-
10 ted to the Federal health care programs of the de-
11 partment or agency initiating the action.

12 “(ii) The Secretary or Administrator of the de-
13 partment or agency initiating the action gives notice
14 and an opportunity to participate in the investiga-
15 tion to the Inspector General of the department or
16 agency with primary jurisdiction over the Federal
17 health care programs to which the claims were sub-
18 mitted.

19 “(B) If the conditions specified in subparagraph (A)
20 are fulfilled, the Inspector General of the department or
21 agency initiating the action is authorized to exercise all
22 powers granted under the Inspector General Act of 1978
23 with respect to the claims submitted to the other depart-
24 ments or agencies to the same manner and extent as pro-

1 vided in that Act with respect to claims submitted to such
2 departments or agencies.”.

3 (b) EXCLUDED INDIVIDUAL RETAINING OWNERSHIP
4 OR CONTROL INTEREST IN PARTICIPATING ENTITY.—

5 Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

6 (1) by striking “or” at the end of paragraph
7 (1)(D);

8 (2) by striking “, or” at the end of paragraph
9 (2) and inserting a semicolon;

10 (3) by striking the semicolon at the end of
11 paragraph (3) and inserting “; or”; and

12 (4) by inserting after paragraph (3) the follow-
13 ing new paragraph:

14 “(4) in the case of a person who is not an orga-
15 nization, agency, or other entity, is excluded from
16 participating in a program under title XVIII or a
17 State health care program in accordance with this
18 subsection or under section 1128 and who, at the
19 time of a violation of this subsection—

20 “(i) retains a direct or indirect ownership
21 or control interest in an entity that is partici-
22 pating in a program under title XVIII or a
23 State health care program, and who knows or
24 should know of the action constituting the basis
25 for the exclusion; or

1 “(ii) is an officer or managing employee
2 (as defined in section 1126(b)) of such an en-
3 tity;”.

4 (c) MODIFICATIONS OF AMOUNTS OF PENALTIES
5 AND ASSESSMENTS.—Section 1128A(a) (42 U.S.C.
6 1320a–7a(a)), as amended by subsection (b), is amended
7 in the matter following paragraph (4)—

8 (1) by striking “\$2,000” and inserting
9 “\$10,000”;

10 (2) by inserting “; in cases under paragraph
11 (4), \$10,000 for each day the prohibited relationship
12 occurs” after “false or misleading information was
13 given”; and

14 (3) by striking “twice the amount” and insert-
15 ing “3 times the amount”.

16 (d) CLAIM FOR ITEM OR SERVICE BASED ON INCOR-
17 RECT CODING OR MEDICALLY UNNECESSARY SERV-
18 ICES.—Section 1128A(a)(1) (42 U.S.C. 1320a–7a(a)(1))
19 is amended—

20 (1) in subparagraph (A) by striking “claimed,”
21 and inserting “claimed, including any person who
22 engages in a pattern or practice of presenting or
23 causing to be presented a claim for an item or serv-
24 ice that is based on a code that the person knows
25 or should know will result in a greater payment to

1 the person than the code the person knows or should
 2 know is applicable to the item or service actually
 3 provided,”;

4 (2) in subparagraph (C), by striking “or” at
 5 the end;

6 (3) in subparagraph (D), by striking “; or” and
 7 inserting “, or”; and

8 (4) by inserting after subparagraph (D) the fol-
 9 lowing new subparagraph:

10 “(E) is for a medical or other item or serv-
 11 ice that a person knows or should know is not
 12 medically necessary; or”.

13 (e) SANCTIONS AGAINST PRACTITIONERS AND PER-
 14 SONS FOR FAILURE TO COMPLY WITH STATUTORY OBLI-
 15 GATIONS.—Section 1156(b)(3) (42 U.S.C. 1320c–5(b)(3))
 16 is amended by striking “the actual or estimated cost” and
 17 inserting “up to \$10,000 for each instance”.

18 (f) PROCEDURAL PROVISIONS.—Section 1876(i)(6)
 19 (42 U.S.C. 1395mm(i)(6)), as amended by section
 20 215(a)(2), is amended by adding at the end the following
 21 new subparagraph:

22 “(D) The provisions of section 1128A (other than
 23 subsections (a) and (b)) shall apply to a civil money pen-
 24 alty under subparagraph (B)(i) or (C)(i) in the same man-

ner as such provisions apply to a civil money penalty or proceeding under section 1128A(a).”.

(g) PROHIBITION AGAINST OFFERING INDUCEMENTS TO INDIVIDUALS ENROLLED UNDER PROGRAMS OR PLANS.—

(1) OFFER OF REMUNERATION.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(A) by striking “or” at the end of paragraph (1)(D);

(B) by striking “, or” at the end of paragraph (2) and inserting a semicolon;

(C) by striking the semicolon at the end of paragraph (3) and inserting “; or”; and

(D) by inserting after paragraph (3) the following new paragraph:

“(4) offers to or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program (as so defined);”.

1 (2) REMUNERATION DEFINED.—Section
2 1128A(i) (42 U.S.C. 1320a–7a(i)) is amended by
3 adding the following new paragraph:

4 “(6) The term ‘remuneration’ includes the waiv-
5 er of coinsurance and deductible amounts (or any
6 part thereof), and transfers of items or services for
7 free or for other than fair market value. The term
8 ‘remuneration’ does not include—

9 “(A) the waiver of coinsurance and deduct-
10 ible amounts by a person, if—

11 “(i) the waiver is not offered as part
12 of any advertisement or solicitation;

13 “(ii) the person does not routinely
14 waive coinsurance or deductible amounts;
15 and

16 “(iii) the person—

17 “(I) waives the coinsurance and
18 deductible amounts after determining
19 in good faith that the individual is in
20 financial need;

21 “(II) fails to collect coinsurance
22 or deductible amounts after making
23 reasonable collection efforts; or

24 “(III) provides for any permis-
25 sible waiver as specified in section

1 1128B(b)(3) or in regulations issued
2 by the Secretary;

3 “(B) differentials in coinsurance and de-
4 ductible amounts as part of a benefit plan de-
5 sign as long as the differentials have been dis-
6 closed in writing to all beneficiaries, third party
7 payers, and providers, to whom claims are pre-
8 sented and as long as the differentials meet the
9 standards as defined in regulations promulgated
10 by the Secretary not later than 180 days after
11 the date of the enactment of the Health Cov-
12 erage Availability and Affordability Act of
13 1996; or

14 “(C) incentives given to individuals to pro-
15 mote the delivery of preventive care as deter-
16 mined by the Secretary in regulations so pro-
17 mulgated.”.

18 (h) EFFECTIVE DATE.—The amendments made by
19 this section shall take effect January 1, 1997.

20 **SEC. 232. CLARIFICATION OF LEVEL OF INTENT REQUIRED**
21 **FOR IMPOSITION OF SANCTIONS.**

22 (a) CLARIFICATION OF LEVEL OF KNOWLEDGE RE-
23 QUIRED FOR IMPOSITION OF CIVIL MONETARY PEN-
24 ALTIES.—

1 (1) IN GENERAL.—Section 1128A(a) (42
2 U.S.C. 1320a–7a(a)) is amended—

3 (A) in paragraphs (1) and (2), by inserting
4 “knowingly” before “presents” each place it ap-
5 pears; and

6 (B) in paragraph (3), by striking “gives”
7 and inserting “knowingly gives or causes to be
8 given”.

9 (2) DEFINITION OF STANDARD.—Section
10 1128A(i) (42 U.S.C. 1320a–7a(i)) is amended by
11 adding at the end the following new paragraph:

12 “(6) The term ‘should know’ means that a per-
13 son, with respect to information—

14 “(A) acts in deliberate ignorance of the
15 truth or falsity of the information; or

16 “(B) acts in reckless disregard of the truth
17 or falsity of the information,

18 and no proof of specific intent to defraud is re-
19 quired.”.

20 (b) EFFECTIVE DATE.—The amendments made by
21 this section shall apply to acts or omissions occurring on
22 or after January 1, 1997.

1 **SEC. 233. PENALTY FOR FALSE CERTIFICATION FOR HOME**
2 **HEALTH SERVICES.**

3 (a) IN GENERAL.—Section 1128A(b) (42 U.S.C.
4 1320a–7a(b)) is amended by adding at the end the follow-
5 ing new paragraph:

6 “(3)(A) Any physician who executes a document de-
7 scribed in subparagraph (B) with respect to an individual
8 knowing that all of the requirements referred to in such
9 subparagraph are not met with respect to the individual
10 shall be subject to a civil monetary penalty of not more
11 than the greater of—

12 “(i) \$5,000, or

13 “(ii) three times the amount of the payments
14 under title XVIII for home health services which are
15 made pursuant to such certification.

16 “(B) A document described in this subparagraph is
17 any document that certifies, for purposes of title XVIII,
18 that an individual meets the requirements of section
19 1814(a)(2)(C) or 1835(a)(2)(A) in the case of home
20 health services furnished to the individual.”.

21 (b) EFFECTIVE DATE.—The amendment made by
22 subsection (a) shall apply to certifications made on or
23 after the date of the enactment of this Act.

1 **Subtitle E—Revisions to Criminal**
2 **Law**

3 **SEC. 241. DEFINITION OF FEDERAL HEALTH CARE OF-**
4 **FENSE.**

5 (a) IN GENERAL.—Chapter 1 of title 18, United
6 States Code, is amended by adding at the end the follow-
7 ing:

8 **“§ 24. Definition of Federal health care offense**

9 “(a) As used in this title, the term ‘Federal health
10 care offense’ means a violation of, or a criminal conspiracy
11 to violate—

12 “(1) section 669, 1035, or 1347 of this title; or

13 “(2) section 287, 371, 664, 666, 1001, 1027,
14 1341, 1343, or 1954 of this title, if the violation or
15 conspiracy relates to a health care benefit program.

16 “(b) As used in this title, the term ‘health care bene-
17 fit program’ has the meaning given such term in section
18 1347(b) of this title.”.

19 (b) CLERICAL AMENDMENT.—The table of sections
20 at the beginning of chapter 2 of title 18, United States
21 Code, is amended by inserting after the item relating to
22 section 23 the following new item:

“24. Definition relating to Federal health care offense defined.”.

23 **SEC. 242. HEALTH CARE FRAUD.**

24 (a) OFFENSE.—

1 (1) IN GENERAL.—Chapter 63 of title 18, Unit-
2 ed States Code, is amended by adding at the end the
3 following:

4 **“§ 1347. Health care fraud**

5 “(a) Whoever knowingly executes, or attempts to exe-
6 cute, a scheme or artifice—

7 “(1) to defraud any health care benefit pro-
8 gram; or

9 “(2) to obtain, by means of false or fraudulent
10 pretenses, representations, or promises, any of the
11 money or property owned by, or under the custody
12 or control of, any health care benefit program;

13 in connection with the delivery of or payment for health
14 care benefits, items, or services, shall be fined under this
15 title or imprisoned not more than 10 years, or both. If
16 the violation results in serious bodily injury (as defined
17 in section 1365 of this title), such person shall be fined
18 under this title or imprisoned not more than 20 years, or
19 both; and if the violation results in death, such person
20 shall be fined under this title, or imprisoned for any term
21 of years or for life, or both.

22 “(b) As used in this section, the term ‘health care
23 benefit program’ means any public or private plan or con-
24 tract, affecting commerce, under which any medical bene-
25 fit, item, or service is provided to any individual, and in-

1 cludes any individual or entity who is providing a medical
 2 benefit, item, or service for which payment may be made
 3 under the plan or contract.”.

4 (2) CLERICAL AMENDMENT.—The table of sec-
 5 tions at the beginning of chapter 63 of title 18,
 6 United States Code, is amended by adding at the
 7 end the following:

“1347. Health care fraud.”.

8 (b) CRIMINAL FINES DEPOSITED IN FEDERAL HOS-
 9 PITAL INSURANCE TRUST FUND.—The Secretary of the
 10 Treasury shall deposit into the Federal Hospital Insurance
 11 Trust Fund pursuant to section 1817(k)(2)(C) of the So-
 12 cial Security Act (42 U.S.C. 1395i) an amount equal to
 13 the criminal fines imposed under section 1347 of title 18,
 14 United States Code (relating to health care fraud).

15 **SEC. 243. THEFT OR EMBEZZLEMENT.**

16 (a) IN GENERAL.—Chapter 31 of title 18, United
 17 States Code, is amended by adding at the end the follow-
 18 ing:

19 **“§ 669. Theft or embezzlement in connection with**
 20 **health care**

21 “(a) Whoever embezzles, steals, or otherwise without
 22 authority willfully and unlawfully converts to the use of
 23 any person other than the rightful owner, or intentionally
 24 misapplies any of the moneys, funds, securities, premiums,
 25 credits, property, or other assets of a health care benefit

1 program, shall be fined under this title or imprisoned not
 2 more than 10 years, or both; but if the value of such prop-
 3 erty does not exceed the sum of \$100 the defendant shall
 4 be fined under this title or imprisoned not more than one
 5 year, or both.

6 “(b) As used in this section, the term ‘health care
 7 benefit program’ has the meaning given such term in sec-
 8 tion 1347(b) of this title.”.

9 (b) CLERICAL AMENDMENT.—The table of sections
 10 at the beginning of chapter 31 of title 18, United States
 11 Code, is amended by adding at the end the following:

“669. Theft or embezzlement in connection with health care.”.

12 **SEC. 244. FALSE STATEMENTS.**

13 (a) IN GENERAL.—Chapter 47 of title 18, United
 14 States Code, is amended by adding at the end the follow-
 15 ing:

16 **“§ 1035. False statements relating to health care mat-
 17 ters**

18 “(a) Whoever, in any matter involving a health care
 19 benefit program, knowingly—

20 “(1) falsifies, conceals, or covers up by any
 21 trick, scheme, or device a material fact; or

22 “(2) makes any false, fictitious, or fraudulent
 23 statements or representations, or makes or uses any
 24 false writing or document knowing the same to con-

tain any false, fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 5 years, or both.

“(b) As used in this section, the term ‘health care benefit program’ has the meaning given such term in section 1347(b) of this title.”.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 47 of title 18, United States Code, is amended by adding at the end the following new item:

“1035. False statements relating to health care matters.”.

SEC. 245. OBSTRUCTION OF CRIMINAL INVESTIGATIONS OF HEALTH CARE OFFENSES.

(a) IN GENERAL.—Chapter 73 of title 18, United States Code, is amended by adding at the end the following:

“§1518. Obstruction of criminal investigations of health care offenses

“(a) Whoever willfully prevents, obstructs, misleads, delays or attempts to prevent, obstruct, mislead, or delay the communication of information or records relating to a violation of a Federal health care offense to a criminal investigator shall be fined under this title or imprisoned not more than 5 years, or both.

1 “(b) As used in this section the term ‘criminal inves-
 2 tigator’ means any individual duly authorized by a depart-
 3 ment, agency, or armed force of the United States to con-
 4 duct or engage in investigations for prosecutions for viola-
 5 tions of health care offenses.”.

6 (b) CLERICAL AMENDMENT.—The table of sections
 7 at the beginning of chapter 73 of title 18, United States
 8 Code, is amended by adding at the end the following new
 9 item:

“1518. Obstruction of criminal investigations of health care offenses.”.

10 **SEC. 246. LAUNDERING OF MONETARY INSTRUMENTS.**

11 Section 1956(c)(7) of title 18, United States Code,
 12 is amended by adding at the end the following:

13 “(F) Any act or activity constituting an of-
 14 fense involving a Federal health care offense.”.

15 **SEC. 247. INJUNCTIVE RELIEF RELATING TO HEALTH CARE**
 16 **OFFENSES.**

17 (a) IN GENERAL.—Section 1345(a)(1) of title 18,
 18 United States Code, is amended—

19 (1) by striking “or” at the end of subparagraph
 20 (A);

21 (2) by inserting “or” at the end of subpara-
 22 graph (B); and

23 (3) by adding at the end the following:

24 “(C) committing or about to commit a
 25 Federal health care offense.”.

1 (b) FREEZING OF ASSETS.—Section 1345(a)(2) of
2 title 18, United States Code, is amended by inserting “or
3 a Federal health care offense”.

4 **SEC. 248. AUTHORIZED INVESTIGATIVE DEMAND PROCE-**
5 **DURES.**

6 (a) IN GENERAL.—Chapter 233 of title 18, United
7 States Code, is amended by adding after section 3485 the
8 following:

9 **“§ 3486. Authorized investigative demand procedures**

10 “(a) AUTHORIZATION.—In any investigation relating
11 to any act or activity involving a Federal health care of-
12 fense, the Attorney General or the Attorney General’s des-
13 ignee may issue in writing and cause to be served a sub-
14 poena requiring the production of any records (including
15 any books, papers, documents, electronic media, or other
16 objects or tangible things), which may be relevant to an
17 authorized law enforcement inquiry, that a person or legal
18 entity may possess or have care, custody, or control. A
19 subpoena shall describe the objects required to be pro-
20 duced and prescribe a return date within a reasonable pe-
21 riod of time within which the objects can be assembled
22 and made available.

23 “(b) SERVICE.—A subpoena issued under this section
24 may be served by any person designated in the subpoena
25 to serve it. Service upon a natural person may be made

1 by personal delivery of the subpoena to him. Service may
2 be made upon a domestic or foreign corporation or upon
3 a partnership or other unincorporated association which
4 is subject to suit under a common name, by delivering the
5 subpoena to an officer, to a managing or general agent,
6 or to any other agent authorized by appointment or by
7 law to receive service of process. The affidavit of the per-
8 son serving the subpoena entered on a true copy thereof
9 by the person serving it shall be proof of service.

10 “(c) ENFORCEMENT.—In the case of contumacy by
11 or refusal to obey a subpoena issued to any person, the
12 Attorney General may invoke the aid of any court of the
13 United States within the jurisdiction of which the inves-
14 tigation is carried on or of which the subpoenaed person
15 is an inhabitant, or in which he carries on business or may
16 be found, to compel compliance with the subpoena. The
17 court may issue an order requiring the subpoenaed person
18 to appear before the Attorney General to produce records,
19 if so ordered, or to give testimony touching the matter
20 under investigation. Any failure to obey the order of the
21 court may be punished by the court as a contempt thereof.
22 All process in any such case may be served in any judicial
23 district in which such person may be found.

24 “(d) IMMUNITY FROM CIVIL LIABILITY.—Notwith-
25 standing any Federal, State, or local law, any person, in-

1 cluding officers, agents, and employees, receiving a sum-
2 mons under this section, who complies in good faith with
3 the summons and thus produces the materials sought,
4 shall not be liable in any court of any State or the United
5 States to any customer or other person for such produc-
6 tion or for nondisclosure of that production to the cus-
7 tomer.

8 “(e) LIMITATION ON USE.—(1) Health information
9 about an individual that is disclosed under this section
10 may not be used in, or disclosed to any person for use
11 in, any administrative, civil, or criminal action or inves-
12 tigation directed against the individual who is the subject
13 of the information unless the action or investigation arises
14 out of and is directly related to receipt of health care or
15 payment for health care or action involving a fraudulent
16 claim related to health; or if authorized by an appropriate
17 order of a court of competent jurisdiction, granted after
18 application showing good cause therefor.

19 “(2) In assessing good cause, the court shall weigh
20 the public interest and the need for disclosure against the
21 injury to the patient, to the physician-patient relationship,
22 and to the treatment services.

23 “(3) Upon the granting of such order, the court, in
24 determining the extent to which any disclosure of all or

1 any part of any record is necessary, shall impose appro-
 2 priate safeguards against unauthorized disclosure.”.

3 (b) CLERICAL AMENDMENT.—The table of sections
 4 at the beginning of chapter 223 of title 18, United States
 5 Code, is amended by inserting after the item relating to
 6 section 3485 the following new item:

“3486. Authorized investigative demand procedures.”.

7 (c) CONFORMING AMENDMENT.—Section
 8 1510(b)(3)(B) of title 18, United States Code, is amended
 9 by inserting “or a Department of Justice subpoena (issued
 10 under section 3486 of title 18),” after “subpoena”.

11 **SEC. 249. FORFEITURES FOR FEDERAL HEALTH CARE OF-**
 12 **FENSES.**

13 (a) IN GENERAL.—Section 982(a) of title 18, United
 14 States Code, is amended by adding after paragraph (5)
 15 the following new paragraph:

16 “(6) The court, in imposing sentence on a person con-
 17 victed of a Federal health care offense, shall order the per-
 18 son to forfeit property, real or personal, that constitutes
 19 or is derived, directly or indirectly, from gross proceeds
 20 traceable to the commission of the offense.”.

21 (b) CONFORMING AMENDMENT.—Section
 22 982(b)(1)(A) of title 18, United States Code, is amended
 23 by inserting “or (a)(6)” after “(a)(1)”.

24 (c) PROPERTY FORFEITED DEPOSITED IN FEDERAL
 25 HOSPITAL INSURANCE TRUST FUND.—

1 (1) IN GENERAL.—After the payment of the
2 costs of asset forfeiture has been made, and notwith-
3 standing any other provision of law, the Secretary of
4 the Treasury shall deposit into the Federal Hospital
5 Insurance Trust Fund pursuant to section
6 1817(k)(2)(C) of the Social Security Act, as added
7 by section 301(b), an amount equal to the net
8 amount realized from the forfeiture of property by
9 reason of a Federal health care offense pursuant to
10 section 982(a)(6) of title 18, United States Code.

11 (2) COSTS OF ASSET FORFEITURE.—For pur-
12 poses of paragraph (1), the term “payment of the
13 costs of asset forfeiture” means—

14 (A) the payment, at the discretion of the
15 Attorney General, of any expenses necessary to
16 seize, detain, inventory, safeguard, maintain,
17 advertise, sell, or dispose of property under sei-
18 zure, detention, or forfeited, or of any other
19 necessary expenses incident to the seizure, de-
20 tention, forfeiture, or disposal of such property,
21 including payment for—

22 (i) contract services,

23 (ii) the employment of outside con-
24 tractors to operate and manage properties
25 or provide other specialized services nec-

1 necessary to dispose of such properties in an
2 effort to maximize the return from such
3 properties; and

4 (iii) reimbursement of any Federal,
5 State, or local agency for any expenditures
6 made to perform the functions described in
7 this subparagraph;

8 (B) at the discretion of the Attorney Gen-
9 eral, the payment of awards for information or
10 assistance leading to a civil or criminal forfeit-
11 ure involving any Federal agency participating
12 in the Health Care Fraud and Abuse Control
13 Account;

14 (C) the compromise and payment of valid
15 liens and mortgages against property that has
16 been forfeited, subject to the discretion of the
17 Attorney General to determine the validity of
18 any such lien or mortgage and the amount of
19 payment to be made, and the employment of at-
20 torneys and other personnel skilled in State real
21 estate law as necessary;

22 (D) payment authorized in connection with
23 remission or mitigation procedures relating to
24 property forfeited; and

1 (E) the payment of State and local prop-
 2 erty taxes on forfeited real property that ac-
 3 crued between the date of the violation giving
 4 rise to the forfeiture and the date of the forfeit-
 5 ure order.

6 **Subtitle F—Administrative** 7 **Simplification**

8 **PART 1—GENERAL ADMINISTRATIVE** 9 **SIMPLIFICATION**

10 **SEC. 251. PURPOSE.**

11 It is the purpose of this part to improve the medicare
 12 program under title XVIII of the Social Security Act, the
 13 medicaid program under title XIX of such Act, and the
 14 efficiency and effectiveness of the health care system, by
 15 encouraging the development of a health information sys-
 16 tem through the establishment of standards and require-
 17 ments for the electronic transmission of certain health in-
 18 formation.

19 **SEC. 252. ADMINISTRATIVE SIMPLIFICATION.**

20 (a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.)
 21 is amended by adding at the end the following:

22 **“PART C—ADMINISTRATIVE SIMPLIFICATION**

23 **“SEC. 1171. DEFINITIONS.**

24 “For purposes of this part:

1 “(1) CLEARINGHOUSE.—The term ‘clearing-
2 house’ means a public or private entity that—

3 “(A) processes or facilitates the processing
4 of nonstandard data elements of health infor-
5 mation into standard data elements; or

6 “(B) provides the means by which persons
7 may meet the requirements of this part.

8 “(2) CODE SET.—The term ‘code set’ means
9 any set of codes used for encoding data elements,
10 such as tables of terms, medical concepts, medical
11 diagnostic codes, or medical procedure codes.

12 “(3) HEALTH CARE PROVIDER.—The term
13 ‘health care provider’ includes a provider of services
14 (as defined in section 1861(u)), a provider of medi-
15 cal or other health services (as defined in section
16 1861(s)), and any other person furnishing health
17 care services or supplies.

18 “(4) HEALTH INFORMATION.—The term ‘health
19 information’ means any information, whether oral or
20 recorded in any form or medium that—

21 “(A) is created or received by a health care
22 provider, health plan, public health authority,
23 employer, life insurer, school or university, or
24 clearinghouse; and

1 “(B) relates to the past, present, or future
2 physical or mental health or condition of an in-
3 dividual, the provision of health care to an indi-
4 vidual, or the past, present, or future payment
5 for the provision of health care to an individual.

6 “(5) HEALTH PLAN.—The term ‘health plan’
7 means a plan which provides, or pays the cost of,
8 health benefits. Such term includes the following, or
9 any combination thereof:

10 “(A) Part A or part B of the medicare
11 program under title XVIII.

12 “(B) The medicaid program under title
13 XIX.

14 “(C) A medicare supplemental policy (as
15 defined in section 1882(g)(1)).

16 “(D) Coverage issued as a supplement to
17 liability insurance.

18 “(E) General liability insurance.

19 “(F) Worker’s compensation or similar in-
20 surance.

21 “(G) Automobile or automobile medical-
22 payment insurance.

23 “(H) A long-term care policy, including a
24 nursing home fixed indemnity policy (unless the
25 Secretary determines that such a policy does

1 not provide sufficiently comprehensive coverage
2 of a benefit so that the policy should be treated
3 as a health plan).

4 “(I) A hospital or fixed indemnity income-
5 protection policy.

6 “(J) An employee welfare benefit plan, as
7 defined in section 3(1) of the Employee Retirement
8 Income Security Act of 1974 (29 U.S.C.
9 1002(1)), but only to the extent the plan is es-
10 tablished or maintained for the purpose of pro-
11 viding health benefits and has 50 or more par-
12 ticipants (as defined in section 3(7) of such
13 Act).

14 “(K) An employee welfare benefit plan or
15 any other arrangement which is established or
16 maintained for the purpose of offering or pro-
17 viding health benefits to the employees of 2 or
18 more employers.

19 “(L) The health care program for active
20 military personnel under title 10, United States
21 Code.

22 “(M) The veterans health care program
23 under chapter 17 of title 38, United States
24 Code.

1 “(N) The Civilian Health and Medical Pro-
2 gram of the Uniformed Services (CHAMPUS),
3 as defined in section 1073(4) of title 10, United
4 States Code.

5 “(O) The Indian health service program
6 under the Indian Health Care Improvement Act
7 (25 U.S.C. 1601 et seq.).

8 “(P) The Federal Employees Health Bene-
9 fit Plan under chapter 89 of title 5, United
10 States Code.

11 “(Q) Such other plan or arrangement as
12 the Secretary determines is a health plan.

13 “(6) INDIVIDUALLY IDENTIFIABLE HEALTH IN-
14 FORMATION.—The term ‘individually identifiable
15 health information’ means any information, includ-
16 ing demographic information collected from an indi-
17 vidual, that—

18 “(A) is created or received by a health care
19 provider, health plan, employer, or clearing-
20 house; and

21 “(B) relates to the past, present, or future
22 physical or mental health or condition of an in-
23 dividual, the provision of health care to an indi-
24 vidual, or the past, present, or future payment

1 for the provision of health care to an individual,
2 and—

3 “(i) identifies the individual; or

4 “(ii) with respect to which there is a
5 reasonable basis to believe that the infor-
6 mation can be used to identify the individ-
7 ual.

8 “(7) STANDARD.—The term ‘standard’, when
9 used with reference to a data element of health in-
10 formation or a transaction referred to in section
11 1173(a)(1), means any such data element or trans-
12 action that meets each of the standards and imple-
13 mentation specifications adopted or established by
14 the Secretary with respect to the data element or
15 transaction under sections 1172 and 1173.

16 “(8) STANDARD SETTING ORGANIZATION.—The
17 term ‘standard setting organization’ means a stand-
18 ard setting organization accredited by the American
19 National Standards Institute, including the National
20 Council for Prescription Drug Programs, that devel-
21 ops standards for information transactions, data ele-
22 ments, or any other standard that is necessary to,
23 or will facilitate, the implementation of this part.

1 **“SEC. 1172. GENERAL REQUIREMENTS FOR ADOPTION OF**
2 **STANDARDS.**

3 “(a) APPLICABILITY.—Any standard or modification
4 of a standard adopted under this part shall apply to the
5 following persons:

6 “(1) A health plan.

7 “(2) A clearinghouse.

8 “(3) A health care provider who transmits any
9 health information in electronic form in connection
10 with a transaction referred to in section 1173(a)(1).

11 “(b) REDUCTION OF COSTS.—Any standard or modi-
12 fication of a standard adopted under this part shall be
13 consistent with the objective of reducing the administra-
14 tive costs of providing and paying for health care.

15 “(c) ROLE OF STANDARD SETTING ORGANIZA-
16 TIONS.—

17 “(1) IN GENERAL.—Except as provided in para-
18 graph (2), any standard or modification of a stand-
19 ard adopted under this part shall be developed or
20 modified by a standard setting organization.

21 “(2) SPECIAL RULES.—

22 “(A) DIFFERENT STANDARDS.—The Sec-
23 retary may adopt a standard or modification of
24 a standard that is different from any standard
25 developed or modified by a standard setting or-
26 ganization, if—

1 “(i) the different standard or modi-
2 fication will substantially reduce adminis-
3 trative costs to health care providers and
4 health plans compared to the alternatives;
5 and

6 “(ii) the standard or modification is
7 promulgated in accordance with the rule-
8 making procedures of subchapter III of
9 chapter 5 of title 5, United States Code.

10 “(B) NO STANDARD BY STANDARD SET-
11 TING ORGANIZATION.—If no standard setting
12 organization has adopted or modified any
13 standard relating to a standard, or a modifica-
14 tion of a standard, that the Secretary is author-
15 ized or required to adopt under this part—

16 “(i) paragraph (1) shall not apply;
17 and

18 “(ii) subsection (f) shall apply.

19 “(d) IMPLEMENTATION SPECIFICATIONS.—The Sec-
20 retary shall establish specifications for implementing each
21 of the standards and modifications adopted under this
22 part.

23 “(e) PROTECTION OF TRADE SECRETS.—Except as
24 otherwise required by law, a standard or modification of
25 a standard adopted under this part shall not require dis-

1 closure of trade secrets or confidential commercial infor-
 2 mation by a person required to comply with this part.

3 “(f) ASSISTANCE TO THE SECRETARY.—In complying
 4 with the requirements of this part, the Secretary shall rely
 5 on the recommendations of the Health Information Advi-
 6 sory Committee established under section 1179 and shall
 7 consult with appropriate Federal and State agencies and
 8 private organizations. The Secretary shall publish in the
 9 Federal Register the recommendations of the Health In-
 10 formation Advisory Committee regarding the adoption of
 11 a standard or modification of a standard under this part.

12 **“SEC. 1173. STANDARDS FOR INFORMATION TRANSACTIONS**
 13 **AND DATA ELEMENTS.**

14 “(a) STANDARDS TO ENABLE ELECTRONIC EX-
 15 CHANGE.—

16 “(1) IN GENERAL.—The Secretary shall adopt
 17 standards for transactions, and data elements for
 18 such transactions, to enable health information to be
 19 exchanged electronically, that are—

20 “(A) appropriate for the financial and ad-
 21 ministrative transactions described in para-
 22 graph (2); and

23 “(B) related to other financial and admin-
 24 istrative transactions determined appropriate by
 25 the Secretary consistent with the goals of im-

1 proving the operation of the health care system
2 and reducing administrative costs.

3 “(2) TRANSACTIONS.—The transactions re-
4 ferred to in paragraph (1)(A) are the following:

5 “(A) Claims (including coordination of
6 benefits) or equivalent encounter information.

7 “(B) Claims attachments.

8 “(C) Enrollment and disenrollment.

9 “(D) Eligibility.

10 “(E) Health care payment and remittance
11 advice.

12 “(F) Premium payments.

13 “(G) First report of injury.

14 “(H) Claims status.

15 “(I) Referral certification and authoriza-
16 tion.

17 “(3) ACCOMMODATION OF SPECIFIC PROVID-
18 ERS.—The standards adopted by the Secretary
19 under paragraph (1) shall accommodate the needs of
20 different types of health care providers.

21 “(b) UNIQUE HEALTH IDENTIFIERS.—

22 “(1) IN GENERAL.—The Secretary shall adopt
23 standards providing for a standard unique health
24 identifier for each individual, employer, health plan,
25 and health care provider for use in the health care

1 system. In carrying out the preceding sentence for
2 each health plan and health care provider, the Sec-
3 retary shall take into account multiple uses for iden-
4 tifiers and multiple locations and specialty classifica-
5 tions for health care providers.

6 “(2) USE OF IDENTIFIERS.—The standards
7 adopted under paragraphs (1) shall specify the pur-
8 poses for which a unique health identifier may be
9 used.

10 “(c) CODE SETS.—

11 “(1) IN GENERAL.—The Secretary shall adopt
12 standards that—

13 “(A) select code sets for appropriate data
14 elements for the transactions referred to in sub-
15 section (a)(1) from among the code sets that
16 have been developed by private and public enti-
17 ties; or

18 “(B) establish code sets for such data ele-
19 ments if no code sets for the data elements
20 have been developed.

21 “(2) DISTRIBUTION.—The Secretary shall es-
22 tablish efficient and low-cost procedures for distribu-
23 tion (including electronic distribution) of code sets
24 and modifications made to such code sets under sec-
25 tion 1174(b).

1 “(d) SECURITY STANDARDS FOR HEALTH INFORMA-
2 TION.—

3 “(1) SECURITY STANDARDS.—The Secretary
4 shall adopt security standards that—

5 “(A) take into account—

6 “(i) the technical capabilities of record
7 systems used to maintain health informa-
8 tion;

9 “(ii) the costs of security measures;

10 “(iii) the need for training persons
11 who have access to health information;

12 “(iv) the value of audit trails in com-
13 puterized record systems; and

14 “(v) the needs and capabilities of
15 small health care providers and rural
16 health care providers (as such providers
17 are defined by the Secretary); and

18 “(B) ensure that a clearinghouse, if it is
19 part of a larger organization, has policies and
20 security procedures which isolate the activities
21 of the clearinghouse with respect to processing
22 information in a manner that prevents unau-
23 thorized access to such information by such
24 larger organization.

1 “(2) SAFEGUARDS.—Each person described in
2 section 1172(a) who maintains or transmits health
3 information shall maintain reasonable and appro-
4 priate administrative, technical, and physical safe-
5 guards—

6 “(A) to ensure the integrity and confiden-
7 tiality of the information;

8 “(B) to protect against any reasonably an-
9 ticipated—

10 “(i) threats or hazards to the security
11 or integrity of the information; and

12 “(ii) unauthorized uses or disclosures
13 of the information; and

14 “(C) otherwise to ensure compliance with
15 this part by the officers and employees of such
16 person.

17 “(e) PRIVACY STANDARDS FOR HEALTH INFORMA-
18 TION.—The Secretary shall adopt standards with respect
19 to the privacy of individually identifiable health informa-
20 tion. Such standards shall include standards concerning
21 at least the following:

22 “(1) The rights of an individual who is a sub-
23 ject of such information.

24 “(2) The procedures to be established for the
25 exercise of such rights.

1 “(3) The uses and disclosures of such informa-
2 tion that are authorized or required.

3 “(f) ELECTRONIC SIGNATURE.—

4 “(1) IN GENERAL.—The Secretary, in coordina-
5 tion with the Secretary of Commerce, shall adopt
6 standards specifying procedures for the electronic
7 transmission and authentication of signatures, com-
8 pliance with which shall be deemed to satisfy Fed-
9 eral and State statutory requirements for written
10 signatures with respect to the transactions referred
11 to in subsection (a)(1).

12 “(2) PAYMENTS FOR SERVICES AND PRE-
13 MIUMS.—Nothing in this part shall be construed to
14 prohibit payment for health care services or health
15 plan premiums by debit, credit, payment card or
16 numbers, or other electronic means.

17 “(g) TRANSFER OF INFORMATION BETWEEN
18 HEALTH PLANS.—The Secretary shall adopt standards
19 for transferring among health plans appropriate standard
20 data elements needed for the coordination of benefits, the
21 sequential processing of claims, and other data elements
22 for individuals who have more than one health plan.

23 **“SEC. 1174. TIMETABLES FOR ADOPTION OF STANDARDS.**

24 “(a) INITIAL STANDARDS.—The Secretary shall
25 carry out section 1173 not later than 18 months after the

1 date of the enactment of this part, except that standards
2 relating to claims attachments shall be adopted not later
3 than 30 months after such date.

4 “(b) ADDITIONS AND MODIFICATIONS TO STAND-
5 ARDS.—

6 “(1) IN GENERAL.—Except as provided in para-
7 graph (2), the Secretary shall review the standards
8 adopted under section 1173, and shall adopt addi-
9 tional or modified standards, as determined appro-
10 priate, but not more frequently than once every 6
11 months. Any addition or modification to a standard
12 shall be completed in a manner which minimizes the
13 disruption and cost of compliance.

14 “(2) SPECIAL RULES.—

15 “(A) FIRST 12-MONTH PERIOD.—Except
16 with respect to additions and modifications to
17 code sets under subparagraph (B), the Sec-
18 retary may not adopt any modification to a
19 standard adopted under this part during the
20 12-month period beginning on the date the
21 standard is initially adopted, unless the Sec-
22 retary determines that the modification is nec-
23 essary in order to permit compliance with the
24 standard.

1 “(B) ADDITIONS AND MODIFICATIONS TO
2 CODE SETS.—

3 “(i) IN GENERAL.—The Secretary
4 shall ensure that procedures exist for the
5 routine maintenance, testing, enhancement,
6 and expansion of code sets.

7 “(ii) ADDITIONAL RULES.—If a code
8 set is modified under this subsection, the
9 modified code set shall include instructions
10 on how data elements of health informa-
11 tion that were encoded prior to the modi-
12 fication may be converted or translated so
13 as to preserve the informational value of
14 the data elements that existed before the
15 modification. Any modification to a code
16 set under this subsection shall be imple-
17 mented in a manner that minimizes the
18 disruption and cost of complying with such
19 modification.

20 **“SEC. 1175. REQUIREMENTS.**

21 “(a) CONDUCT OF TRANSACTIONS BY PLANS.—

22 “(1) IN GENERAL.—If a person desires to con-
23 duct a transaction referred to in section 1173(a)(1)
24 with a health plan as a standard transaction—

1 “(A) the health plan may not refuse to
2 conduct such transaction as a standard trans-
3 action;

4 “(B) the health plan may not delay such
5 transaction, or otherwise adversely affect, or at-
6 tempt to adversely affect, the person or the
7 transaction on the ground that the transaction
8 is a standard transaction; and

9 “(C) the information transmitted and re-
10 ceived in connection with the transaction shall
11 be in the form of standard data elements of
12 health information.

13 “(2) SATISFACTION OF REQUIREMENTS.—A
14 health plan may satisfy the requirements under
15 paragraph (1) by—

16 “(A) directly transmitting and receiving
17 standard data elements of health information;
18 or

19 “(B) submitting nonstandard data ele-
20 ments to a clearinghouse for processing into
21 standard data elements and transmission by the
22 clearinghouse, and receiving standard data ele-
23 ments through the clearinghouse.

24 “(3) TIMETABLE FOR COMPLIANCE.—Para-
25 graph (1) shall not be construed to require a health

1 plan to comply with any standard, implementation
2 specification, or modification to a standard or speci-
3 fication adopted or established by the Secretary
4 under sections 1172 and 1173 at any time prior to
5 the date on which the plan is required to comply
6 with the standard or specification under subsection
7 (b).

8 “(b) COMPLIANCE WITH STANDARDS.—

9 “(1) INITIAL COMPLIANCE.—

10 “(A) IN GENERAL.—Not later than 24
11 months after the date on which an initial stand-
12 ard or implementation specification is adopted
13 or established under sections 1172 and 1173,
14 each person to whom the standard or imple-
15 mentation specification applies shall comply
16 with the standard or specification.

17 “(B) SPECIAL RULE FOR SMALL HEALTH
18 PLANS.—In the case of a small health plan,
19 paragraph (1) shall be applied by substituting
20 “36 months” for “24 months”. For purposes of
21 this subsection, the Secretary shall determine
22 the plans that qualify as small health plans.

23 “(2) COMPLIANCE WITH MODIFIED STAND-
24 ARDS.—If the Secretary adopts a modification to a
25 standard or implementation specification under this

1 part, each person to whom the standard or imple-
 2 mentation specification applies shall comply with the
 3 modified standard or implementation specification at
 4 such time as the Secretary determines appropriate,
 5 taking into account the time needed to comply due
 6 to the nature and extent of the modification. The
 7 time determined appropriate under the preceding
 8 sentence may not be earlier than the last day of the
 9 180-day period beginning on the date such modifica-
 10 tion is adopted. The Secretary may extend the time
 11 for compliance for small health plans, if the Sec-
 12 retary determines that such extension is appropriate.

13 **“SEC. 1176. GENERAL PENALTY FOR FAILURE TO COMPLY**
 14 **WITH REQUIREMENTS AND STANDARDS.**

15 “(a) GENERAL PENALTY.—

16 “(1) IN GENERAL.—Except as provided in sub-
 17 section (b), the Secretary shall impose on any person
 18 who violates a provision of this part a penalty of not
 19 more than \$100 for each such violation, except that
 20 the total amount imposed on the person for all viola-
 21 tions of an identical requirement or prohibition dur-
 22 ing a calendar year may not exceed \$25,000.

23 “(2) PROCEDURES.—The provisions of section
 24 1128A (other than subsections (a) and (b) and the
 25 second sentence of subsection (f)) shall apply to the

1 imposition of a civil money penalty under this sub-
2 section in the same manner as such provisions apply
3 to the imposition of a penalty under such section
4 1128A.

5 “(b) LIMITATIONS.—

6 “(1) OFFENSES OTHERWISE PUNISHABLE.—A
7 penalty may not be imposed under subsection (a)
8 with respect to an act if the act constitutes an of-
9 fense punishable under section 1177.

10 “(2) NONCOMPLIANCE NOT DISCOVERED.—A
11 penalty may not be imposed under subsection (a)
12 with respect to a provision of this part if it is estab-
13 lished to the satisfaction of the Secretary that the
14 person liable for the penalty did not know, and by
15 exercising reasonable diligence would not have
16 known, that such person violated the provision.

17 “(3) FAILURES DUE TO REASONABLE CAUSE.—

18 “(A) IN GENERAL.—Except as provided in
19 subparagraph (B), a penalty may not be im-
20 posed under subsection (a) if—

21 “(i) the failure to comply was due to
22 reasonable cause and not to willful neglect;
23 and

24 “(ii) the failure to comply is corrected
25 during the 30-day period beginning on the

1 first date the person liable for the penalty
2 knew, or by exercising reasonable diligence
3 would have known, that the failure to com-
4 ply occurred.

5 “(B) EXTENSION OF PERIOD.—

6 “(i) NO PENALTY.—The period re-
7 ferred to in subparagraph (A)(ii) may be
8 extended as determined appropriate by the
9 Secretary based on the nature and extent
10 of the failure to comply.

11 “(ii) ASSISTANCE.—If the Secretary
12 determines that a person failed to comply
13 because the person was unable to comply,
14 the Secretary may provide technical assist-
15 ance to the person during the period de-
16 scribed in subparagraph (A)(ii). Such as-
17 sistance shall be provided in any manner
18 determined appropriate by the Secretary.

19 “(4) REDUCTION.—In the case of a failure to
20 comply which is due to reasonable cause and not to
21 willful neglect, any penalty under subsection (a) that
22 is not entirely waived under paragraph (3) may be
23 waived to the extent that the payment of such pen-
24 alty would be excessive relative to the compliance
25 failure involved.

1 **“SEC. 1177. WRONGFUL DISCLOSURE OF INDIVIDUALLY**
2 **IDENTIFIABLE HEALTH INFORMATION.**

3 “(a) OFFENSE.—A person who knowingly and in vio-
4 lation of this part—

5 “(1) uses or causes to be used a unique health
6 identifier;

7 “(2) obtains individually identifiable health in-
8 formation relating to an individual; or

9 “(3) discloses individually identifiable health in-
10 formation to another person,
11 shall be punished as provided in subsection (b).

12 “(b) PENALTIES.—A person described in subsection
13 (a) shall—

14 “(1) be fined not more than \$50,000, impris-
15 oned not more than 1 year, or both;

16 “(2) if the offense is committed under false pre-
17 tenses, be fined not more than \$100,000, imprisoned
18 not more than 5 years, or both; and

19 “(3) if the offense is committed with intent to
20 sell, transfer, or use individually identifiable health
21 information for commercial advantage, personal
22 gain, or malicious harm, fined not more than
23 \$250,000, imprisoned not more than 10 years, or
24 both.

25 **“SEC. 1178. EFFECT ON STATE LAW.**

26 “(a) GENERAL EFFECT.—

1 “(1) GENERAL RULE.—Except as provided in
2 paragraph (2), a provision or requirement under this
3 part, or a standard or implementation specification
4 adopted or established under sections 1172 and
5 1173, shall supersede any contrary provision of
6 State law, including a provision of State law that re-
7 quires medical or health plan records (including bill-
8 ing information) to be maintained or transmitted in
9 written rather than electronic form.

10 “(2) EXCEPTIONS.—A provision or requirement
11 under this part, or a standard or implementation
12 specification adopted or established under sections
13 1172 and 1173, shall not supersede a contrary pro-
14 vision of State law, if the provision of State law—

15 “(A) imposes requirements, standards, or
16 implementation specifications that are more
17 stringent than the requirements, standards, or
18 implementation specifications under this part
19 with respect to the privacy of individually iden-
20 tifiable health information; or

21 “(B) is a provision the Secretary deter-
22 mines—

23 “(i) is necessary to prevent fraud and
24 abuse, or for other purposes; or

25 “(ii) addresses controlled substances.

1 “(b) PUBLIC HEALTH REPORTING.—Nothing in this
2 part shall be construed to invalidate or limit the authority,
3 power, or procedures established under any law providing
4 for the reporting of disease or injury, child abuse, birth,
5 or death, public health surveillance, or public health inves-
6 tigation or intervention.

7 **“SEC. 1179. HEALTH INFORMATION ADVISORY COMMITTEE.**

8 “(a) ESTABLISHMENT.—There is established a com-
9 mittee to be known as the Health Information Advisory
10 Committee (in this section referred to as the ‘committee’).

11 “(b) DUTIES.—The committee shall—

12 “(1) provide assistance to the Secretary in com-
13 plying with the requirements imposed on the Sec-
14 retary under this part;

15 “(2) study the issues related to the adoption of
16 uniform data standards for patient medical record
17 information and the electronic exchange of such in-
18 formation;

19 “(3) report to the Secretary not later than 4
20 years after the date of the enactment of this part
21 recommendations and legislative proposals for such
22 standards and electronic exchange; and

23 “(4) generally be responsible for advising the
24 Secretary and the Congress on the status of the im-
25 plementation of this part.

1 “(c) MEMBERSHIP.—

2 “(1) IN GENERAL.—The committee shall con-
3 sist of 15 members of whom—

4 “(A) 3 shall be appointed by the President;

5 “(B) 6 shall be appointed by the Speaker
6 of the House of Representatives after consulta-
7 tion with the minority leader of the House of
8 Representatives; and

9 “(C) 6 shall be appointed by the President
10 pro tempore of the Senate after consultation
11 with the minority leader of the Senate.

12 The appointments of the members shall be made not
13 later than 60 days after the date of the enactment
14 of this part. The President shall designate 1 member
15 as the Chair.

16 “(2) EXPERTISE.—The membership of the com-
17 mittee shall consist of individuals who are of recog-
18 nized standing and distinction in the areas of infor-
19 mation systems, information networking and inte-
20 gration, consumer health, health care financial man-
21 agement, or privacy, and who possess the dem-
22 onstrated capacity to discharge the duties imposed
23 on the committee.

24 “(3) TERMS.—Each member of the committee
25 shall be appointed for a term of 5 years, except that

1 the members first appointed shall serve staggered
2 terms such that the terms of not more than 3 mem-
3 bers expire at one time.

4 “(4) INITIAL MEETING.—Not later than 30
5 days after the date on which a majority of the mem-
6 bers have been appointed, the committee shall hold
7 its first meeting.

8 “(d) REPORTS.—Not later than 1 year after the date
9 of the enactment of this part, and annually thereafter, the
10 committee shall submit to the Congress, and make public,
11 a report regarding—

12 “(1) the extent to which persons required to
13 comply with this part are cooperating in implement-
14 ing the standards adopted under this part;

15 “(2) the extent to which such entities are meet-
16 ing the privacy and security standards adopted
17 under this part and the types of penalties assessed
18 for noncompliance with such standards;

19 “(3) whether the Federal and State Govern-
20 ments are receiving information of sufficient quality
21 to meet their responsibilities under this part;

22 “(4) any problems that exist with respect to im-
23 plementation of this part; and

24 “(5) the extent to which timetables under this
25 part are being met.”.

1 (b) CONFORMING AMENDMENTS.—

2 (1) REQUIREMENT FOR MEDICARE PROVID-
3 ERS.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1))
4 is amended—

5 (A) by striking “and” at the end of sub-
6 paragraph (P);

7 (B) by striking the period at the end of
8 subparagraph (Q) and inserting “; and”; and

9 (C) by inserting immediately after sub-
10 paragraph (Q) the following new subparagraph:

11 “(R) to contract only with a clearinghouse
12 (as defined in section 1171) that meets each
13 standard and implementation specification
14 adopted or established under sections 1172 and
15 1173 on or after the date on which the clear-
16 inghouse is required to comply with the stand-
17 ard or specification.”.

18 (2) CLERICAL AMENDMENTS.—

19 (A) Title XI (42 U.S.C. 1301 et seq.) is
20 amended by striking the title heading and in-
21 serting the following:

1 “TITLE XI—GENERAL PROVISIONS, PEER RE-
 2 VIEW, AND ADMINISTRATIVE SIMPLIFICA-
 3 TION”.

4 (B) Parts A and B of title XI (42 U.S.C.
 5 1301 et seq.) are amended by striking “this
 6 title” each place such term appears and insert-
 7 ing “parts A and B of this title”.

8 **PART 2—ADMINISTRATIVE SIMPLIFICATION FOR**
 9 **LABORATORY SERVICES**

10 **SEC. 261. ADMINISTRATIVE SIMPLIFICATION FOR LABORA-**
 11 **TORY SERVICES.**

12 (a) IN GENERAL.—Not later than 1 year after the
 13 date of the enactment of this Act, the Secretary of Health
 14 and Human Services (in accordance with the process de-
 15 scribed in subsection (b)) shall adopt uniform coverage,
 16 administration, and payment policies for clinical diag-
 17 nostic laboratory tests under part B of the medicare pro-
 18 gram.

19 (b) PROCESS FOR ADOPTION OF POLICIES.—The
 20 Secretary shall adopt uniform policies under subsection
 21 (a) in accordance with the following process:

22 (1) The Secretary shall select from carriers
 23 with whom the Secretary has a contract under part
 24 B during 1996 15 medical directors, who will meet
 25 and develop recommendations for such uniform poli-

1 cies. The medical directors selected shall represent
2 various geographic areas and have a varied range of
3 experience in relevant medical fields, including pa-
4 thology and clinical laboratory practice.

5 (2) The medical directors selected under para-
6 graph (1) shall consult with independent experts in
7 each major discipline of clinical laboratory medicine
8 including clinical laboratory personnel, bioanalysts,
9 pathologists, and practicing physicians. The medical
10 directors shall also solicit comments from other indi-
11 viduals and groups who wish to participate, includ-
12 ing consumers and other affected parties. This proc-
13 ess shall be conducted as a negotiated rulemaking
14 under title 5, United States Code.

15 (3) Under the negotiated rulemaking, the rec-
16 ommendations for uniform policies shall be designed
17 to simplify and reduce unnecessary administrative
18 burdens in connection with the following:

19 (A) Beneficiary information required to be
20 submitted with each claim.

21 (B) Physicians' obligations regarding docu-
22 mentation requirements and recordkeeping.

23 (C) Procedures for filing claims and for
24 providing remittances by electronic media.

1 (D) The performance of post-payment re-
2 view of test claims.

3 (E) The prohibition of the documentation
4 of medical necessity except when determined to
5 be appropriate after identification of aberrant
6 utilization pattern through focused medical re-
7 view.

8 (F) Beneficiary responsibility for payment.

9 (4) During the pendency of the adoption by the
10 Secretary of the uniform policies, fiscal
11 intermediaries and carriers under the Medicare pro-
12 gram may not implement any new requirement relat-
13 ing to the submission of a claim for clinical diag-
14 nostic laboratory tests retroactive to January 1,
15 1996, and carriers may not initiate any new cov-
16 erage, administrative, or payment policy unless the
17 policy promotes the goal of administrative simplifica-
18 tion of requirements imposed on clinical laboratories
19 in accordance with the Secretary's promulgation of
20 the negotiated rulemaking.

21 (5) Not later than 6 months after the date of
22 the enactment of this Act, the medical directors shall
23 submit their recommendations to the Secretary, and
24 the Secretary shall publish the recommendations and
25 solicit public comment using negotiated rulemaking

1 in accordance with title 5, United States Code. The
2 Secretary shall publish final uniform policies for cov-
3 erage, administration, and payment of claims for
4 clinical diagnostic laboratory tests, effective after the
5 expiration of the 180-day period which begins on the
6 date of publication.

7 (6) After the publication of the final uniform
8 policies, the Secretary shall implement identical uni-
9 form documentation and processing policies for all
10 clinical diagnostic laboratory tests paid under the
11 Medicare program through fiscal intermediaries or
12 carriers.

13 (c) OPTIONAL SELECTION OF SINGLE CARRIER.—Ef-
14 fective for claims submitted after the expiration of the 90-
15 day period which begins on the date of the enactment of
16 this Act, an independent laboratory may select a single
17 carrier for the processing of all of its claims for payment
18 under part B of the medicare program, without regard to
19 the location where the laboratory or the patient or pro-
20 vider involved resides or conducts business. Such election
21 of a single carrier shall be made by the clinical laboratory
22 and an agreement made between the carrier and the lab-
23 oratory shall be forwarded to the Secretary of Health and
24 Human Services. Nothing in this subsection shall be con-

1 strued to require a laboratory to select a single carrier
 2 under this subsection.

3 (d) CONSISTENCY WITH GENERAL ADMINISTRATIVE
 4 SIMPLIFICATION.—In complying with this section, the
 5 Secretary shall ensure that the policies adopted under sub-
 6 section (a) are consistent, to the maximum extent prac-
 7 ticable, with part C of title XI of the Social Security Act.

8 **TITLE III—TAX-RELATED** 9 **HEALTH PROVISIONS**

10 **SEC. 300. AMENDMENT OF 1986 CODE.**

11 Except as otherwise expressly provided, whenever in
 12 this title an amendment or repeal is expressed in terms
 13 of an amendment to, or repeal of, a section or other provi-
 14 sion, the reference shall be considered to be made to a
 15 section or other provision of the Internal Revenue Code
 16 of 1986.

17 **Subtitle A—Medical Savings** 18 **Accounts**

19 **SEC. 301. MEDICAL SAVINGS ACCOUNTS.**

20 (a) IN GENERAL.—Part VII of subchapter B of chap-
 21 ter 1 (relating to additional itemized deductions for indi-
 22 viduals) is amended by redesignating section 220 as sec-
 23 tion 221 and by inserting after section 219 the following
 24 new section:

1 **“SEC. 220. MEDICAL SAVINGS ACCOUNTS.**

2 “(a) DEDUCTION ALLOWED.—In the case of an indi-
3 vidual who is an eligible individual for any month during
4 the taxable year, there shall be allowed as a deduction for
5 the taxable year an amount equal to the aggregate amount
6 paid in cash during such taxable year by such individual
7 to a medical savings account of such individual.

8 “(b) LIMITATIONS.—

9 “(1) IN GENERAL.—Except as otherwise pro-
10 vided in this subsection, the amount allowable as a
11 deduction under subsection (a) to an individual for
12 the taxable year shall not exceed—

13 “(A) except as provided in subparagraph
14 (B), the lesser of—

15 “(i) \$2,000, or

16 “(ii) the annual deductible limit for
17 any individual covered under the high de-
18 ductible health plan, or

19 “(B) in the case of a high deductible
20 health plan covering the taxpayer and any other
21 eligible individual who is the spouse or any de-
22 pendent (as defined in section 152) of the tax-
23 payer, the lesser of—

24 “(i) \$4,000, or

1 “(ii) the annual limit under the plan
2 on the aggregate amount of deductibles re-
3 quired to be paid by all individuals.

4 The preceding sentence shall not apply if the spouse
5 of such individual is covered under any other high
6 deductible health plan.

7 “(2) SPECIAL RULE FOR MARRIED INDIVID-
8 UALS.—

9 “(A) IN GENERAL.—This subsection shall
10 be applied separately for each married individ-
11 ual.

12 “(B) SPECIAL RULE.—If individuals who
13 are married to each other are covered under the
14 same high deductible health plan, then the
15 amounts applicable under paragraph (1)(B)
16 shall be divided equally between them unless
17 they agree on a different division.

18 “(3) COORDINATION WITH EXCLUSION FOR EM-
19 PLOYER CONTRIBUTIONS.—No deduction shall be al-
20 lowed under this section for any amount paid for
21 any taxable year to a medical savings account of an
22 individual if—

23 “(A) any amount is paid to any medical
24 savings account of such individual which is ex-

1 cludable from gross income under section
2 106(b) for such year, or

3 “(B) in a case described in paragraph (2),
4 any amount is paid to any medical savings ac-
5 count of either spouse which is so excludable for
6 such year.

7 “(4) PRORATION OF LIMITATION.—

8 “(A) IN GENERAL.—The limitation under
9 paragraph (1) shall be the sum of the monthly
10 limitations for months during the taxable year
11 that the individual is an eligible individual if—

12 “(i) such individual is not an eligible
13 individual for all months of the taxable
14 year,

15 “(ii) the deductible under the high de-
16 ductible health plan covering such individ-
17 ual is not the same throughout such tax-
18 able year, or

19 “(iii) such limitation is determined
20 under paragraph (1)(B) for some but not
21 all months during such taxable year.

22 “(B) MONTHLY LIMITATION.—The month-
23 ly limitation for any month shall be an amount
24 equal to $\frac{1}{12}$ of the limitation which would (but
25 for this paragraph and paragraph (3)) be deter-

mined under paragraph (1) if the facts and circumstances as of the first day of such month that such individual is covered under a high deductible health plan were true for the entire taxable year.

“(5) DENIAL OF DEDUCTION TO DEPENDENTS.—No deduction shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual’s taxable year begins.

“(c) DEFINITIONS.—For purposes of this section—

“(1) ELIGIBLE INDIVIDUAL.—

“(A) IN GENERAL.—The term ‘eligible individual’ means, with respect to any month, any individual—

“(i) who is covered under a high deductible health plan as of the 1st day of such month, and

“(ii) who is not, while covered under a high deductible health plan, covered under any health plan—

“(I) which is not a high deductible health plan, and

1 “(II) which provides coverage for
2 any benefit which is covered under the
3 high deductible health plan.

4 “(B) CERTAIN COVERAGE DIS-
5 REGARDED.—Subparagraph (A)(ii) shall be ap-
6 plied without regard to—

7 “(i) coverage for any benefit provided
8 by permitted insurance, and

9 “(ii) coverage (whether through insur-
10 ance or otherwise) for accidents, disability,
11 dental care, vision care, or long-term care.

12 “(2) HIGH DEDUCTIBLE HEALTH PLAN.—The
13 term ‘high deductible health plan’ means a health
14 plan which—

15 “(A) has an annual deductible limit for
16 each individual covered by the plan which is not
17 less than \$1,500, and

18 “(B) has an annual limit on the aggregate
19 amount of deductibles required to be paid with
20 respect to all individuals covered by the plan
21 which is not less than \$3,000.

22 Such term does not include a health plan if substan-
23 tially all of its coverage is coverage described in
24 paragraph (1)(B). A plan shall not fail to be treated
25 as a high deductible health plan by reason of failing

1 to have a deductible for preventive care if the ab-
2 sence of a deductible for such care is required by
3 State law.

4 “(3) PERMITTED INSURANCE.—The term ‘per-
5 mitted insurance’ means—

6 “(A) Medicare supplemental insurance,

7 “(B) insurance if substantially all of the
8 coverage provided under such insurance relates
9 to—

10 “(i) liabilities incurred under workers’
11 compensation laws,

12 “(ii) tort liabilities,

13 “(iii) liabilities relating to ownership
14 or use of property, or

15 “(iv) such other similar liabilities as
16 the Secretary may specify by regulations,

17 “(C) insurance for a specified disease or
18 illness, and

19 “(D) insurance paying a fixed amount per
20 day (or other period) of hospitalization.

21 “(d) MEDICAL SAVINGS ACCOUNT.—For purposes of
22 this section—

23 “(1) MEDICAL SAVINGS ACCOUNT.—The term
24 ‘medical savings account’ means a trust created or
25 organized in the United States exclusively for the

1 purpose of paying the qualified medical expenses of
2 the account holder, but only if the written governing
3 instrument creating the trust meets the following re-
4 quirements:

5 “(A) Except in the case of a rollover con-
6 tribution described in subsection (f)(5), no con-
7 tribution will be accepted—

8 “(i) unless it is in cash, or

9 “(ii) to the extent such contribution,
10 when added to previous contributions to
11 the trust for the calendar year, exceeds
12 \$4,000.

13 “(B) The trustee is a bank (as defined in
14 section 408(n)), an insurance company (as de-
15 fined in section 816), or another person who
16 demonstrates to the satisfaction of the Sec-
17 retary that the manner in which such person
18 will administer the trust will be consistent with
19 the requirements of this section.

20 “(C) No part of the trust assets will be in-
21 vested in life insurance contracts.

22 “(D) The assets of the trust will not be
23 commingled with other property except in a
24 common trust fund or common investment
25 fund.

1 “(E) The interest of an individual in the
2 balance in his account is nonforfeitable.

3 “(2) QUALIFIED MEDICAL EXPENSES.—

4 “(A) IN GENERAL.—The term ‘qualified
5 medical expenses’ means, with respect to an ac-
6 count holder, amounts paid by such holder
7 for—

8 “(i) medical care (as defined in sec-
9 tion 213(d)), or

10 “(ii) qualified long-term care services
11 (as defined in section 7702B(c)),
12 for such individual, the spouse of such individ-
13 ual, and any dependent (as defined in section
14 152) of such individual, but only to the extent
15 such amounts are not compensated for by in-
16 surance or otherwise.

17 “(B) HEALTH INSURANCE MAY NOT BE
18 PURCHASED FROM ACCOUNT.—

19 “(i) IN GENERAL.—Subparagraph (A)
20 shall not apply to any payment for insur-
21 ance.

22 “(ii) EXCEPTIONS.—Clause (i) shall
23 not apply to any expense for coverage
24 under—

1 “(I) a health plan during any pe-
2 riod of continuation coverage required
3 under any Federal law,

4 “(II) a qualified long-term care
5 insurance contract (as defined in sec-
6 tion 7702B(b)), or

7 “(III) a health plan during a pe-
8 riod in which the individual is receiv-
9 ing unemployment compensation
10 under any Federal or State law.

11 “(C) CERTAIN PAYMENTS TO RELATIVES
12 TREATED AS NOT PAID FOR MEDICAL CARE.—
13 For purposes of subparagraph (A), an amount
14 paid for any service provided to an individual
15 shall in no event be treated as a qualified long-
16 term care service if such service is provided—

17 “(i) by the spouse of the individual or
18 by a relative (directly or through a part-
19 nership, corporation, or other entity) un-
20 less the service is provided by a licensed
21 professional with respect to such service, or

22 “(ii) by a corporation or partnership
23 which is related (within the meaning of
24 section 267(b) or 707(b)) to the individual.

1 For purposes of this subparagraph, the term
2 ‘relative’ means an individual bearing a rela-
3 tionship to the individual which is described in
4 any of paragraphs (1) through (8) of section
5 152(a).

6 “(3) ACCOUNT HOLDER.—The term ‘account
7 holder’ means the individual on whose behalf the
8 medical savings account was established.

9 “(4) CERTAIN RULES TO APPLY.—Rules similar
10 to the following rules shall apply for purposes of this
11 section:

12 “(A) Section 219(d)(2) (relating to no de-
13 duction for rollovers).

14 “(B) Section 219(f)(3) (relating to time
15 when contributions deemed made).

16 “(C) Except as provided in section 106(b),
17 section 219(f)(5) (relating to employer pay-
18 ments).

19 “(D) Section 408(g) (relating to commu-
20 nity property laws).

21 “(E) Section 408(h) (relating to custodial
22 accounts).

23 “(e) TAX TREATMENT OF ACCOUNTS.—

24 “(1) IN GENERAL.—A medical savings account
25 is exempt from taxation under this subtitle unless

1 such account has ceased to be a medical savings ac-
2 count by reason of paragraph (2) or (3). Notwith-
3 standing the preceding sentence, any such account is
4 subject to the taxes imposed by section 511 (relating
5 to imposition of tax on unrelated business income
6 of charitable, etc. organizations).

7 “(2) ACCOUNT TERMINATIONS.—Rules similar
8 to the rules of paragraphs (2) and (4) of section
9 408(e) shall apply to medical savings accounts, and
10 any amount treated as distributed under such rules
11 shall be treated as not used to pay qualified medical
12 expenses.

13 “(f) TAX TREATMENT OF DISTRIBUTIONS.—

14 “(1) AMOUNTS USED FOR QUALIFIED MEDICAL
15 EXPENSES.—

16 “(A) IN GENERAL.—Any amount paid or
17 distributed out of a medical savings account
18 which is used exclusively to pay qualified medi-
19 cal expenses of any account holder (or any
20 spouse or dependent of the holder) shall not be
21 includible in gross income.

22 “(B) TREATMENT AFTER DEATH OF AC-
23 COUNT HOLDER.—

24 “(i) TREATMENT IF HOLDER IS
25 SPOUSE.—If, after the death of the ac-

1 count holder, the account holder's interest
2 is payable to (or for the benefit of) the
3 holder's spouse, the medical savings ac-
4 count shall be treated as if the spouse were
5 the account holder.

6 “(ii) TREATMENT IF DESIGNATED
7 HOLDER IS NOT SPOUSE.—In the case of
8 an account holder's interest in a medical
9 savings account which is payable to (or for
10 the benefit of) any person other than such
11 holder's spouse upon the death of such
12 holder—

13 “(I) such account shall cease to
14 be a medical savings account as of the
15 date of death, and

16 “(II) an amount equal to the fair
17 market value of the assets in such ac-
18 count on such date shall be includible
19 if such person is not the estate of
20 such holder, in such person's gross in-
21 come for the taxable year which in-
22 cludes such date, or if such person is
23 the estate of such holder, in such
24 holder's gross income for the last tax-
25 able year of such holder.

1 “(2) INCLUSION OF AMOUNTS NOT USED FOR
2 QUALIFIED MEDICAL EXPENSES.—

3 “(A) IN GENERAL.—Any amount paid or
4 distributed out of a medical savings account
5 which is not used exclusively to pay the quali-
6 fied medical expenses of the account holder or
7 of the spouse or dependents of such holder shall
8 be included in the gross income of such holder.

9 “(B) SPECIAL RULES.—For purposes of
10 subparagraph (A)—

11 “(i) all medical savings accounts of
12 the account holder shall be treated as 1 ac-
13 count,

14 “(ii) all payments and distributions
15 during any taxable year shall be treated as
16 1 distribution, and

17 “(iii) any distribution of property
18 shall be taken into account at its fair mar-
19 ket value on the date of the distribution.

20 “(3) EXCESS CONTRIBUTIONS RETURNED BE-
21 FORE DUE DATE OF RETURN.—Paragraph (2) shall
22 not apply to the distribution of any contribution paid
23 during a taxable year to a medical savings account
24 to the extent that such contribution exceeds the
25 amount under subsection (d)(1)(A)(ii) if—

1 “(A) such distribution is received by the
2 individual on or before the last day prescribed
3 by law (including extensions of time) for filing
4 such individual’s return for such taxable year,
5 and

6 “(B) such distribution is accompanied by
7 the amount of net income attributable to such
8 excess contribution.

9 Any net income described in subparagraph (B) shall
10 be included in the gross income of the individual for
11 the taxable year in which it is received.

12 “(4) PENALTY FOR DISTRIBUTIONS NOT USED
13 FOR QUALIFIED MEDICAL EXPENSES.—

14 “(A) IN GENERAL.—The tax imposed by
15 this chapter on the account holder for any tax-
16 able year in which there is a payment or dis-
17 tribution from a medical savings account of
18 such holder which is includible in gross income
19 under paragraph (2) shall be increased by 10
20 percent of the amount which is so includible.

21 “(B) EXCEPTION FOR DISABILITY OR
22 DEATH.—Subparagraph (A) shall not apply if
23 the payment or distribution is made after the
24 account holder becomes disabled within the
25 meaning of section 72(m)(7) or dies.

1 “(C) EXCEPTION FOR DISTRIBUTIONS
2 AFTER AGE 59½.—Subparagraph (A) shall not
3 apply to any payment or distribution after the
4 date on which the account holder attains age
5 59½.

6 “(5) ROLLOVER CONTRIBUTION.—An amount is
7 described in this paragraph as a rollover contribu-
8 tion if it meets the requirements of subparagraphs
9 (A) and (B).

10 “(A) IN GENERAL.—Paragraph (2) shall
11 not apply to any amount paid or distributed
12 from a medical savings account to the account
13 holder to the extent the amount received is paid
14 into a medical savings account for the benefit
15 of such holder not later than the 60th day after
16 the day on which the holder receives the pay-
17 ment or distribution.

18 “(B) LIMITATION.—This paragraph shall
19 not apply to any amount described in subpara-
20 graph (A) received by an individual from a
21 medical savings account if, at any time during
22 the 1-year period ending on the day of such re-
23 ceipt, such individual received any other amount
24 described in subparagraph (A) from a medical
25 savings account which was not includible in the

1 individual's gross income because of the appli-
2 cation of this paragraph.

3 “(6) COORDINATION WITH MEDICAL EXPENSE
4 DEDUCTION.—For purposes of determining the
5 amount of the deduction under section 213, any pay-
6 ment or distribution out of a medical savings ac-
7 count for qualified medical expenses shall not be
8 treated as an expense paid for medical care.

9 “(7) TRANSFER OF ACCOUNT INCIDENT TO DI-
10 VORCE.—The transfer of an individual's interest in
11 a medical savings account to an individual's spouse
12 or former spouse under a divorce or separation in-
13 strument described in subparagraph (A) of section
14 71(b)(2) shall not be considered a taxable transfer
15 made by such individual notwithstanding any other
16 provision of this subtitle, and such interest shall,
17 after such transfer, be treated as a medical savings
18 account with respect to which the spouse is the ac-
19 count holder.

20 “(g) COST-OF-LIVING ADJUSTMENT.—

21 “(1) IN GENERAL.—In the case of any taxable
22 year beginning in a calendar year after 1997, each
23 dollar amount in subsection (b)(1), (c)(2), or
24 (d)(1)(A) shall be increased by an amount equal
25 to—

1 “(A) such dollar amount, multiplied by

2 “(B) the medical care cost adjustment for
3 such calendar year.

4 If any increase under the preceding sentence is not
5 a multiple of \$50, such increase shall be rounded to
6 the nearest multiple of \$50.

7 “(2) MEDICAL CARE COST ADJUSTMENT.—For
8 purposes of paragraph (1), the medical care cost ad-
9 justment for any calendar year is the percentage (if
10 any) by which—

11 “(A) the medical care component of the
12 Consumer Price Index (as defined in section
13 1(f)(5)) for August of the preceding calendar
14 year, exceeds

15 “(B) such component for August of 1996.

16 “(h) REPORTS.—The Secretary may require the
17 trustee of a medical savings account to make such reports
18 regarding such account to the Secretary and to the ac-
19 count holder with respect to contributions, distributions,
20 and such other matters as the Secretary determines appro-
21 priate. The reports required by this subsection shall be
22 filed at such time and in such manner and furnished to
23 such individuals at such time and in such manner as may
24 be required by those regulations.”

1 (b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL
2 ITEMIZES OTHER DEDUCTIONS.—Subsection (a)
3 of section 62 is amended by inserting after paragraph (15)
4 the following new paragraph:

5 “(16) MEDICAL SAVINGS ACCOUNTS.—The de-
6 duction allowed by section 220.”

7 (c) EXCLUSIONS FOR EMPLOYER CONTRIBUTIONS TO
8 MEDICAL SAVINGS ACCOUNTS.—

9 (1) EXCLUSION FROM INCOME TAX.—The text
10 of section 106 (relating to contributions by employer
11 to accident and health plans) is amended to read as
12 follows:

13 “(a) GENERAL RULE.—Gross income of an employee
14 does not include employer-provided coverage under an ac-
15 cident or health plan.

16 “(b) CONTRIBUTIONS TO MEDICAL SAVINGS AC-
17 COUNTS.—

18 “(1) IN GENERAL.—In the case of an employee
19 who is an eligible individual, gross income does not
20 include amounts contributed by such employee’s em-
21 ployer to any medical savings account of such em-
22 ployee.

23 “(2) COORDINATION WITH DEDUCTION LIMITA-
24 TION.—The amount excluded from the gross income
25 of an employee under this subsection for any taxable

1 year shall not exceed the limitation under section
2 220(b)(1) (determined without regard to this sub-
3 section) which is applicable to such employee for
4 such taxable year.

5 “(3) NO CONSTRUCTIVE RECEIPT.—No amount
6 shall be included in the gross income of any em-
7 ployee solely because the employee may choose be-
8 tween the contributions referred to in paragraph (1)
9 and employer contributions to another health plan of
10 the employer.

11 “(4) SPECIAL RULE FOR DEDUCTION OF EM-
12 PLOYER CONTRIBUTIONS.—Any employer contribu-
13 tion to a medical savings account, if otherwise allow-
14 able as a deduction under this chapter, shall be al-
15 lowed only for the taxable year in which paid.

16 “(5) DEFINITIONS.—For purposes of this sub-
17 section, the terms ‘eligible individual’ and ‘medical
18 savings account’ have the respective meanings given
19 to such terms by section 220.”

20 (2) EXCLUSION FROM EMPLOYMENT TAXES.—

21 (A) SOCIAL SECURITY TAXES.—

22 (i) Subsection (a) of section 3121 is
23 amended by striking “or” at the end of
24 paragraph (20), by striking the period at
25 the end of paragraph (21) and inserting “;

1 or”, and by inserting after paragraph (21)
2 the following new paragraph:

3 “(22) any payment made to or for the benefit
4 of an employee if at the time of such payment it is
5 reasonable to believe that the employee will be able
6 to exclude such payment from income under section
7 106(b).”

8 (ii) Subsection (a) of section 209 of
9 the Social Security Act is amended by
10 striking “or” at the end of paragraph (17),
11 by striking the period at the end of para-
12 graph (18) and inserting “; or”, and by in-
13 serting after paragraph (18) the following
14 new paragraph:

15 “(19) any payment made to or for the benefit
16 of an employee if at the time of such payment it is
17 reasonable to believe that the employee will be able
18 to exclude such payment from income under section
19 106(b) of the Internal Revenue Code of 1986.”

20 (B) RAILROAD RETIREMENT TAX.—Sub-
21 section (e) of section 3231 is amended by add-
22 ing at the end the following new paragraph:

23 “(10) MEDICAL SAVINGS ACCOUNT CONTRIBU-
24 TIONS.—The term ‘compensation’ shall not include
25 any payment made to or for the benefit of an em-

1 ployee if at the time of such payment it is reason-
2 able to believe that the employee will be able to ex-
3 clude such payment from income under section
4 106(b).”

5 (C) UNEMPLOYMENT TAX.—Subsection (b)
6 of section 3306 is amended by striking “or” at
7 the end of paragraph (15), by striking the pe-
8 riod at the end of paragraph (16) and inserting
9 “; or”, and by inserting after paragraph (16)
10 the following new paragraph:

11 “(17) any payment made to or for the benefit
12 of an employee if at the time of such payment it is
13 reasonable to believe that the employee will be able
14 to exclude such payment from income under section
15 106(b).”

16 (D) WITHHOLDING TAX.—Subsection (a)
17 of section 3401 is amended by striking “or” at
18 the end of paragraph (19), by striking the pe-
19 riod at the end of paragraph (20) and inserting
20 “; or”, and by inserting after paragraph (20)
21 the following new paragraph:

22 “(21) any payment made to or for the benefit
23 of an employee if at the time of such payment it is
24 reasonable to believe that the employee will be able

1 to exclude such payment from income under section
2 106(b).”

3 (d) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS
4 NOT AVAILABLE UNDER CAFETERIA PLANS.—Subsection
5 (f) of section 125 of such Code is amended by inserting
6 “106(b),” before “117”.

7 (e) EXCLUSION OF MEDICAL SAVINGS ACCOUNTS
8 FROM ESTATE TAX.—Part IV of subchapter A of chapter
9 11 is amended by adding at the end the following new
10 section:

11 **“SEC. 2057. MEDICAL SAVINGS ACCOUNTS.**

12 “For purposes of the tax imposed by section 2001,
13 the value of the taxable estate shall be determined by de-
14 ducting from the value of the gross estate an amount
15 equal to the value of any medical savings account (as de-
16 fined in section 220(d)) included in the gross estate.”

17 (f) TAX ON EXCESS CONTRIBUTIONS.—Section 4973
18 (relating to tax on excess contributions to individual re-
19 tirement accounts, certain section 403(b) contracts, and
20 certain individual retirement annuities) is amended—

21 (1) by inserting “**MEDICAL SAVINGS AC-**
22 **COUNTS,**” after “**ACCOUNTS,**” in the heading of
23 such section,

24 (2) by striking “or” at the end of paragraph
25 (1) of subsection (a),

1 (3) by redesignating paragraph (2) of sub-
2 section (a) as paragraph (3) and by inserting after
3 paragraph (1) the following:

4 “(2) a medical savings account (within the
5 meaning of section 220(d)), or”, and

6 (4) by adding at the end the following new sub-
7 section:

8 “(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS
9 ACCOUNTS.—For purposes of this section, in the case of
10 a medical savings account (within the meaning of section
11 220(d)), the term ‘excess contributions’ means the sum
12 of—

13 “(1) the amount by which the amount contrib-
14 uted for the taxable year to the account exceeds the
15 amount which may be contributed to the account
16 under section 220(d)(1)(B)(ii) for such taxable year,
17 and

18 “(2) the amount determined under this sub-
19 section for the preceding taxable year, reduced by
20 the sum of distributions out of the account included
21 in gross income under section 220(f) (2) or (3) and
22 the excess (if any) of the maximum amount allow-
23 able as a deduction under section 220 for the tax-
24 able year over the amount contributed.

1 For purposes of this subsection, any contribution which
2 is distributed out of the medical savings account in a dis-
3 tribution to which section 220(f)(3) applies shall be treat-
4 ed as an amount not contributed.”

5 (g) TAX ON PROHIBITED TRANSACTIONS.—

6 (1) Section 4975 (relating to tax on prohibited
7 transactions) is amended by adding at the end of
8 subsection (c) the following new paragraph:

9 “(4) SPECIAL RULE FOR MEDICAL SAVINGS AC-
10 COUNTS.—An individual for whose benefit a medical
11 savings account (within the meaning of section
12 220(d)) is established shall be exempt from the tax
13 imposed by this section with respect to any trans-
14 action concerning such account (which would other-
15 wise be taxable under this section) if, with respect
16 to such transaction, the account ceases to be a medi-
17 cal savings account by reason of the application of
18 section 220(e)(2) to such account.”

19 (2) Paragraph (1) of section 4975(e) is amend-
20 ed to read as follows:

21 “(1) PLAN.—For purposes of this section, the
22 term ‘plan’ means—

23 “(A) a trust described in section 401(a)
24 which forms a part of a plan, or a plan de-

1 scribed in section 403(a), which trust or plan is
2 exempt from tax under section 501(a),

3 “(B) an individual retirement account de-
4 scribed in section 408(a),

5 “(C) an individual retirement annuity de-
6 scribed in section 408(b),

7 “(D) a medical savings account described
8 in section 220(d), or

9 “(E) a trust, plan, account, or annuity
10 which, at any time, has been determined by the
11 Secretary to be described in any preceding sub-
12 paragraph of this paragraph.”

13 (h) FAILURE TO PROVIDE REPORTS ON MEDICAL
14 SAVINGS ACCOUNTS.—

15 (1) Subsection (a) of section 6693 (relating to
16 failure to provide reports on individual retirement
17 accounts or annuities) is amended to read as follows:

18 “(a) REPORTS.—

19 “(1) IN GENERAL.—If a person required to file
20 a report under a provision referred to in paragraph
21 (2) fails to file such report at the time and in the
22 manner required by such provision, such person
23 shall pay a penalty of \$50 for each failure unless it
24 is shown that such failure is due to reasonable
25 cause.

1 “(2) PROVISIONS.—The provisions referred to
2 in this paragraph are—

3 “(A) subsections (i) and (l) of section 408
4 (relating to individual retirement plans), and
5 “(B) section 220(h) (relating to medical
6 savings accounts).”

7 (i) EXCEPTION FROM CAPITALIZATION OF POLICY
8 ACQUISITION EXPENSES.—Subparagraph (B) of section
9 848(e)(1) (defining specified insurance contract) is
10 amended by striking “and” at the end of clause (ii), by
11 striking the period at the end of clause (iii) and inserting
12 “, and”, and by adding at the end the following new
13 clause:

14 “(iv) any contract which is a medical
15 savings account (as defined in section
16 220(d)).”.

17 (j) CLERICAL AMENDMENT.—The table of sections
18 for part VII of subchapter B of chapter 1 is amended by
19 striking the last item and inserting the following:

 “Sec. 220. Medical savings accounts.
 “Sec. 221. Cross reference.”

20 (k) EFFECTIVE DATE.—The amendments made by
21 this section shall apply to taxable years beginning after
22 December 31, 1996.

1 **Subtitle B—Increase in Deduction**
 2 **for Health Insurance Costs of**
 3 **Self-Employed Individuals**

4 **SEC. 311. INCREASE IN DEDUCTION FOR HEALTH INSUR-**
 5 **ANCE COSTS OF SELF-EMPLOYED INDIVID-**
 6 **UALS.**

7 (a) IN GENERAL.—Paragraph (1) of section 162(l)
 8 is amended to read as follows:

9 “(1) ALLOWANCE OF DEDUCTION.—

10 “(A) IN GENERAL.—In the case of an indi-
 11 vidual who is an employee within the meaning
 12 of section 401(c)(1), there shall be allowed as
 13 a deduction under this section an amount equal
 14 to the applicable percentage of the amount paid
 15 during the taxable year for insurance which
 16 constitutes medical care for the taxpayer, his
 17 spouse, and dependents.

18 “(B) APPLICABLE PERCENTAGE.—For
 19 purposes of subparagraph (A), the applicable
 20 percentage shall be determined under the fol-
 21 lowing table:

“For taxable years beginning in calendar year—	The applicable percentage is—
1998, 1999, or 2000	35 percent
2001 or 2002	40 percent
2003 or thereafter	50 percent.”

1 (b) EFFECTIVE DATE.—The amendment made by
 2 this section shall apply to taxable years beginning after
 3 December 31, 1997.

4 **Subtitle C—Long-Term Care** 5 **Services and Contracts**

6 **PART I—GENERAL PROVISIONS**

7 **SEC. 321. TREATMENT OF LONG-TERM CARE INSURANCE.**

8 (a) GENERAL RULE.—Chapter 79 (relating to defini-
 9 tions) is amended by inserting after section 7702A the fol-
 10 lowing new section:

11 **“SEC. 7702B. TREATMENT OF QUALIFIED LONG-TERM CARE** 12 **INSURANCE.**

13 “(a) IN GENERAL.—For purposes of this title—

14 “(1) a qualified long-term care insurance con-
 15 tract shall be treated as an accident and health in-
 16 surance contract,

17 “(2) amounts (other than policyholder divi-
 18 dends, as defined in section 808, or premium re-
 19 funds) received under a qualified long-term care in-
 20 surance contract shall be treated as amounts re-
 21 ceived for personal injuries and sickness and shall be
 22 treated as reimbursement for expenses actually in-
 23 curred for medical care (as defined in section
 24 213(d)),

1 “(3) any plan of an employer providing cov-
2 erage under a qualified long-term care insurance
3 contract shall be treated as an accident and health
4 plan with respect to such coverage,

5 “(4) except as provided in subsection (e)(3),
6 amounts paid for a qualified long-term care insur-
7 ance contract providing the benefits described in
8 subsection (b)(2)(A) shall be treated as payments
9 made for insurance for purposes of section
10 213(d)(1)(D), and

11 “(5) a qualified long-term care insurance con-
12 tract shall be treated as a guaranteed renewable con-
13 tract subject to the rules of section 816(e).

14 “(b) QUALIFIED LONG-TERM CARE INSURANCE
15 CONTRACT.—For purposes of this title—

16 “(1) IN GENERAL.—The term ‘qualified long-
17 term care insurance contract’ means any insurance
18 contract if—

19 “(A) the only insurance protection pro-
20 vided under such contract is coverage of quali-
21 fied long-term care services,

22 “(B) such contract does not pay or reim-
23 burse expenses incurred for services or items to
24 the extent that such expenses are reimbursable
25 under title XVIII of the Social Security Act or

1 would be so reimbursable but for the applica-
2 tion of a deductible or coinsurance amount,

3 “(C) such contract is guaranteed renew-
4 able,

5 “(D) such contract does not provide for a
6 cash surrender value or other money that can
7 be—

8 “(i) paid, assigned, or pledged as col-
9 lateral for a loan, or

10 “(ii) borrowed,
11 other than as provided in subparagraph (E) or
12 paragraph (2)(C),

13 “(E) all refunds of premiums, and all pol-
14 icyholder dividends or similar amounts, under
15 such contract are to be applied as a reduction
16 in future premiums or to increase future bene-
17 fits, and

18 “(F) such contract meets the requirements
19 of subsection (f).

20 “(2) SPECIAL RULES.—

21 “(A) PER DIEM, ETC. PAYMENTS PER-
22 MITTED.—A contract shall not fail to be de-
23 scribed in subparagraph (A) or (B) of para-
24 graph (1) by reason of payments being made on
25 a per diem or other periodic basis without re-

1 gard to the expenses incurred during the period
2 to which the payments relate.

3 “(B) SPECIAL RULES RELATING TO MEDI-
4 CARE.—

5 “(i) Paragraph (1)(B) shall not apply
6 to expenses which are reimbursable under
7 title XVIII of the Social Security Act only
8 as a secondary payor.

9 “(ii) No provision of law shall be con-
10 strued or applied so as to prohibit the of-
11 fering of a qualified long-term care insur-
12 ance contract on the basis that the con-
13 tract coordinates its benefits with those
14 provided under such title.

15 “(C) REFUNDS OF PREMIUMS.—Paragraph
16 (1)(E) shall not apply to any refund on the
17 death of the insured, or on a complete surren-
18 der or cancellation of the contract, which can-
19 not exceed the aggregate premiums paid under
20 the contract. Any refund on a complete surren-
21 der or cancellation of the contract shall be in-
22 cludible in gross income to the extent that any
23 deduction or exclusion was allowable with re-
24 spect to the premiums.

1 “(c) QUALIFIED LONG-TERM CARE SERVICES.—For
2 purposes of this section—

3 “(1) IN GENERAL.—The term ‘qualified long-
4 term care services’ means necessary diagnostic, pre-
5 ventive, therapeutic, curing, treating, mitigating, and
6 rehabilitative services, and maintenance or personal
7 care services, which—

8 “(A) are required by a chronically ill indi-
9 vidual, and

10 “(B) are provided pursuant to a plan of
11 care prescribed by a licensed health care practi-
12 tioner.

13 “(2) CHRONICALLY ILL INDIVIDUAL.—

14 “(A) IN GENERAL.—The term ‘chronically
15 ill individual’ means any individual who has
16 been certified by a licensed health care practi-
17 tioner as—

18 “(i) being unable to perform (without
19 substantial assistance from another indi-
20 vidual) at least 2 activities of daily living
21 for a period of at least 90 days due to a
22 loss of functional capacity,

23 “(ii) having a level of disability simi-
24 lar (as determined by the Secretary in con-
25 sultation with the Secretary of Health and

1 Human Services) to the level of disability
2 described in clause (i), or

3 “(iii) requiring substantial supervision
4 to protect such individual from threats to
5 health and safety due to severe cognitive
6 impairment.

7 Such term shall not include any individual oth-
8 erwise meeting the requirements of the preced-
9 ing sentence unless within the preceding 12-
10 month period a licensed health care practitioner
11 has certified that such individual meets such re-
12 quirements.

13 “(B) ACTIVITIES OF DAILY LIVING.—For
14 purposes of subparagraph (A), each of the fol-
15 lowing is an activity of daily living:

16 “(i) Eating.

17 “(ii) Toileting.

18 “(iii) Transferring.

19 “(iv) Bathing.

20 “(v) Dressing.

21 “(vi) Continence.

22 Nothing in this section shall be construed to re-
23 quire a contract to take into account all of the
24 preceding activities of daily living.

1 “(3) MAINTENANCE OR PERSONAL CARE SERV-
2 ICES.—The term ‘maintenance or personal care serv-
3 ices’ means any care the primary purpose of which
4 is the provision of needed assistance with any of the
5 disabilities as a result of which the individual is a
6 chronically ill individual (including the protection
7 from threats to health and safety due to severe cog-
8 nitive impairment).

9 “(4) LICENSED HEALTH CARE PRACTI-
10 TIONER.—The term ‘licensed health care practi-
11 tioner’ means any physician (as defined in section
12 1861(r)(1) of the Social Security Act) and any reg-
13 istered professional nurse, licensed social worker, or
14 other individual who meets such requirements as
15 may be prescribed by the Secretary.

16 “(d) AGGREGATE PAYMENTS IN EXCESS OF LIM-
17 ITS.—

18 “(1) IN GENERAL.—If the aggregate amount of
19 periodic payments under all qualified long-term care
20 insurance contracts with respect to an insured for
21 any period exceeds the dollar amount in effect for
22 such period under paragraph (3), such excess pay-
23 ments shall be treated as made for qualified long-
24 term care services only to the extent of the costs in-
25 curred by the payee (not otherwise compensated for

1 by insurance or otherwise) for qualified long-term
2 care services provided during such period for such
3 insured.

4 “(2) PERIODIC PAYMENTS.—For purposes of
5 paragraph (1), the term ‘periodic payment’ means
6 any payment (whether on a periodic basis or other-
7 wise) made without regard to the extent of the costs
8 incurred by the payee for qualified long-term care
9 services.

10 “(3) DOLLAR AMOUNT.—The dollar amount in
11 effect under this subsection shall be \$175 per day
12 (or the equivalent amount in the case of payments
13 on another periodic basis).

14 “(4) INFLATION ADJUSTMENT.—In the case of
15 a calendar year after 1997, the dollar amount con-
16 tained in paragraph (3) shall be increased at the
17 same time and in the same manner as amounts are
18 increased pursuant to section 213(d)(10).

19 “(e) TREATMENT OF COVERAGE PROVIDED AS PART
20 OF A LIFE INSURANCE CONTRACT.—Except as otherwise
21 provided in regulations prescribed by the Secretary, in the
22 case of any long-term care insurance coverage (whether
23 or not qualified) provided by a rider on or as part of a
24 life insurance contract—

1 “(1) IN GENERAL.—This section shall apply as
2 if the portion of the contract providing such cov-
3 erage is a separate contract.

4 “(2) APPLICATION OF 7702.—Section
5 7702(e)(2) (relating to the guideline premium limi-
6 tation) shall be applied by increasing the guideline
7 premium limitation with respect to a life insurance
8 contract, as of any date—

9 “(A) by the sum of any charges (but not
10 premium payments) against the life insurance
11 contract’s cash surrender value (within the
12 meaning of section 7702(f)(2)(A)) for such cov-
13 erage made to that date under the contract, less

14 “(B) any such charges the imposition of
15 which reduces the premiums paid for the con-
16 tract (within the meaning of section
17 7702(f)(1)).

18 “(3) APPLICATION OF SECTION 213.—No deduc-
19 tion shall be allowed under section 213(a) for
20 charges against the life insurance contract’s cash
21 surrender value described in paragraph (2), unless
22 such charges are includible in income as a result of
23 the application of section 72(e)(10) and the rider is
24 a qualified long-term care insurance contract under
25 subsection (b).

1 “(4) PORTION DEFINED.—For purposes of this
 2 subsection, the term ‘portion’ means only the terms
 3 and benefits under a life insurance contract that are
 4 in addition to the terms and benefits under the con-
 5 tract without regard to the coverage under a quali-
 6 fied long-term care insurance contract.”

7 (b) LONG-TERM CARE INSURANCE NOT PERMITTED
 8 UNDER CAFETERIA PLANS OR FLEXIBLE SPENDING AR-
 9 RANGEMENTS.—

10 (1) CAFETERIA PLANS.—Section 125(f) is
 11 amended by adding at the end the following new
 12 sentence: “Such term shall not include any long-
 13 term care insurance contract (as defined in section
 14 4980C).”

15 (2) FLEXIBLE SPENDING ARRANGEMENTS.—
 16 The text of section 106 (relating to contributions by
 17 employer to accident and health plans) is amended
 18 to read as follows:

19 “(a) GENERAL RULE.—Except as provided in sub-
 20 section (b), gross income of an employee does not include
 21 employer-provided coverage under an accident or health
 22 plan.

23 “(b) INCLUSION OF LONG-TERM CARE BENEFITS
 24 PROVIDED THROUGH FLEXIBLE SPENDING ARRANGE-
 25 MENTS.—

1 “(1) IN GENERAL.—Effective on and after Jan-
 2 uary 1, 1997, gross income of an employee shall in-
 3 clude employer-provided coverage for qualified long-
 4 term care services (as defined in section 7702B(c))
 5 to the extent that such coverage is provided through
 6 a flexible spending or similar arrangement.

7 “(2) FLEXIBLE SPENDING ARRANGEMENT.—
 8 For purposes of this subsection, a flexible spending
 9 arrangement is a benefit program which provides
 10 employees with coverage under which—

11 “(A) specified incurred expenses may be
 12 reimbursed (subject to reimbursement maxi-
 13 mums and other reasonable conditions), and

14 “(B) the maximum amount of reimburse-
 15 ment which is reasonably available to a partici-
 16 pant for such coverage is less than 500 percent
 17 of the value of such coverage.

18 In the case of an insured plan, the maximum
 19 amount reasonably available shall be determined on
 20 the basis of the underlying coverage.”

21 (c) CONTINUATION COVERAGE EXCISE TAX NOT TO
 22 APPLY.—Subsection (f) of section 4980B is amended by
 23 adding at the end the following new paragraph:

24 “(9) CONTINUATION OF LONG-TERM CARE COV-
 25 ERAGE NOT REQUIRED.—A group health plan shall

1 not be treated as failing to meet the requirements of
2 this subsection solely by reason of failing to provide
3 coverage under any qualified long-term care insur-
4 ance contract (as defined in section 7702B(b)).”

5 (d) CLERICAL AMENDMENT.—The table of sections
6 for chapter 79 is amended by inserting after the item re-
7 lating to section 7702A the following new item:

“Sec. 7702B. Treatment of qualified long-term care insurance.”.

8 (e) EFFECTIVE DATE.—

9 (1) IN GENERAL.—The amendments made by
10 this section shall apply to contracts issued after De-
11 cember 31, 1996.

12 (2) CONTINUATION OF EXISTING POLICIES.—In
13 the case of any contract issued before January 1,
14 1997, which met the long-term care insurance re-
15 quirements of the State in which the contract was
16 situated at the time the contract was issued—

17 (A) such contract shall be treated for pur-
18 poses of the Internal Revenue Code of 1986 as
19 a qualified long-term care insurance contract
20 (as defined in section 7702B(b) of such Code),
21 and

22 (B) services provided under, or reimbursed
23 by, such contract shall be treated for such pur-
24 poses as qualified long-term care services (as
25 defined in section 7702B(c) of such Code).

1 (3) EXCHANGES OF EXISTING POLICIES.—If,
2 after the date of enactment of this Act and before
3 January 1, 1998, a contract providing for long-term
4 care insurance coverage is exchanged solely for a
5 qualified long-term care insurance contract (as de-
6 fined in section 7702B(b) of such Code), no gain or
7 loss shall be recognized on the exchange. If, in addi-
8 tion to a qualified long-term care insurance contract,
9 money or other property is received in the exchange,
10 then any gain shall be recognized to the extent of
11 the sum of the money and the fair market value of
12 the other property received. For purposes of this
13 paragraph, the cancellation of a contract providing
14 for long-term care insurance coverage and reinvest-
15 ment of the cancellation proceeds in a qualified long-
16 term care insurance contract within 60 days there-
17 after shall be treated as an exchange.

18 (4) ISSUANCE OF CERTAIN RIDERS PER-
19 MITTED.—For purposes of applying sections 101(f),
20 7702, and 7702A of the Internal Revenue Code of
21 1986 to any contract—

22 (A) the issuance of a rider which is treated
23 as a qualified long-term care insurance contract
24 under section 7702B, and

1 (B) the addition of any provision required
 2 to conform any other long-term care rider to be
 3 so treated,
 4 shall not be treated as a modification or material
 5 change of such contract.

6 **SEC. 322. PREMIUMS FOR QUALIFIED LONG-TERM CARE IN-**
 7 **SURANCE TREATED AS PAYMENT FOR MEDI-**
 8 **CAL CARE.**

9 (a) GENERAL RULE.—Paragraph (1) of section
 10 213(d) (defining medical care) is amended by striking
 11 “or” at the end of subparagraph (B), by striking the pe-
 12 riod at the end of subparagraph (C) and inserting “, or”,
 13 and by adding at the end the following new subparagraph:

14 “(D) for eligible long-term care pre-
 15 miums.”

16 (b) ELIGIBLE LONG-TERM CARE PREMIUMS.—Sub-
 17 section (d) of section 213 is amended by adding at the
 18 end the following new paragraph:

19 “(10) ELIGIBLE LONG-TERM CARE PRE-
 20 MIUMS.—

21 “(A) IN GENERAL.—For purposes of this
 22 section, the term ‘eligible long-term care pre-
 23 miums’ means the amount paid during a tax-
 24 able year for any qualified long-term care insur-
 25 ance contract (as defined in section 7702B(b))

covering an individual, to the extent such amount does not exceed the limitation determined under the following table:

“In the case of an individual with an attained age before the close of the taxable year of:	The limitation is:
40 or less	\$200
More than 40 but not more than 50	375
More than 50 but not more than 60	750
More than 60 but not more than 70	2,000
More than 70	2,500.

“(B) INDEXING.—

“(i) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1997, each dollar amount contained in subparagraph (A) shall be increased by the medical care cost adjustment of such amount for such calendar year. If any increase determined under the preceding sentence is not a multiple of \$10, such increase shall be rounded to the nearest multiple of \$10.

“(ii) MEDICAL CARE COST ADJUSTMENT.—For purposes of clause (i), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

“(I) the medical care component of the Consumer Price Index (as de-

1 fined in section 1(f)(5)) for August of
 2 the preceding calendar year, exceeds
 3 “(II) such component for August
 4 of 1996.

5 The Secretary shall, in consultation with
 6 the Secretary of Health and Human Serv-
 7 ices, prescribe an adjustment which the
 8 Secretary determines is more appropriate
 9 for purposes of this paragraph than the
 10 adjustment described in the preceding sen-
 11 tence, and the adjustment so prescribed
 12 shall apply in lieu of the adjustment de-
 13 scribed in the preceding sentence.”

14 (c) EFFECTIVE DATE.—The amendments made by
 15 this section shall apply to taxable years beginning after
 16 December 31, 1996.

17 **SEC. 323. REPORTING REQUIREMENTS.**

18 (a) IN GENERAL.—Subpart B of part III of sub-
 19 chapter A of chapter 61 is amended by adding at the end
 20 the following new section:

21 **“SEC. 6050Q. CERTAIN LONG-TERM CARE BENEFITS.**

22 “(a) REQUIREMENT OF REPORTING.—Any person
 23 who pays long-term care benefits shall make a return, ac-
 24 cording to the forms or regulations prescribed by the Sec-
 25 retary, setting forth—

1 “(1) the aggregate amount of such benefits
2 paid by such person to any individual during any
3 calendar year, and

4 “(2) the name, address, and TIN of such indi-
5 vidual.

6 “(b) STATEMENTS TO BE FURNISHED TO PERSONS
7 WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—
8 Every person required to make a return under subsection
9 (a) shall furnish to each individual whose name is required
10 to be set forth in such return a written statement show-
11 ing—

12 “(1) the name of the person making the pay-
13 ments, and

14 “(2) the aggregate amount of long-term care
15 benefits paid to the individual which are required to
16 be shown on such return.

17 The written statement required under the preceding sen-
18 tence shall be furnished to the individual on or before Jan-
19 uary 31 of the year following the calendar year for which
20 the return under subsection (a) was required to be made.

21 “(c) LONG-TERM CARE BENEFITS.—For purposes of
22 this section, the term ‘long-term care benefit’ means any
23 amount paid under a long-term care insurance policy
24 (within the meaning of section 4980C(e)).”.

25 (b) PENALTIES.—

1 (1) Subparagraph (B) of section 6724(d)(1) is
 2 amended by redesignating clauses (ix) through (xiv)
 3 as clauses (x) through (xv), respectively, and by in-
 4 serting after clause (viii) the following new clause:

5 “(ix) section 6050Q (relating to cer-
 6 tain long-term care benefits),”.

7 (2) Paragraph (2) of section 6724(d) is amend-
 8 ed by redesignating subparagraphs (Q) through (T)
 9 as subparagraphs (R) through (U), respectively, and
 10 by inserting after subparagraph (P) the following
 11 new subparagraph:

12 “(Q) section 6050Q(b) (relating to certain
 13 long-term care benefits),”.

14 (c) CLERICAL AMENDMENT.—The table of sections
 15 for subpart B of part III of subchapter A of chapter 61
 16 is amended by adding at the end the following new item:

 “Sec. 6050Q. Certain long-term care benefits.”

17 (d) EFFECTIVE DATE.—The amendments made by
 18 this section shall apply to benefits paid after December
 19 31, 1996.

20 **PART II—CONSUMER PROTECTION PROVISIONS**

21 **SEC. 325. POLICY REQUIREMENTS.**

22 Section 7702B (as added by section 321) is amended
 23 by adding at the end the following new subsection:

24 “(f) CONSUMER PROTECTION PROVISIONS.—

1 “(1) IN GENERAL.—The requirements of this
 2 subsection are met with respect to any contract if
 3 any long-term care insurance policy issued under the
 4 contract meets—

5 “(A) the requirements of the model regula-
 6 tion and model Act described in paragraph (2),

7 “(B) the disclosure requirement of para-
 8 graph (3), and

9 “(C) the requirements relating to
 10 nonforfeitability under paragraph (4).

11 “(2) REQUIREMENTS OF MODEL REGULATION
 12 AND ACT.—

13 “(A) IN GENERAL.—The requirements of
 14 this paragraph are met with respect to any pol-
 15 icy if such policy meets—

16 “(i) MODEL REGULATION.—The fol-
 17 lowing requirements of the model regula-
 18 tion:

19 “(I) Section 7A (relating to guar-
 20 anteed renewal or noncancellability),
 21 and the requirements of section 6B of
 22 the model Act relating to such section
 23 7A.

1 “(II) Section 7B (relating to pro-
2 hibitions on limitations and exclu-
3 sions).

4 “(III) Section 7C (relating to ex-
5 tension of benefits).

6 “(IV) Section 7D (relating to
7 continuation or conversion of cov-
8 erage).

9 “(V) Section 7E (relating to dis-
10 continuance and replacement of poli-
11 cies).

12 “(VI) Section 8 (relating to unin-
13 tentional lapse).

14 “(VII) Section 9 (relating to dis-
15 closure), other than section 9F there-
16 of.

17 “(VIII) Section 10 (relating to
18 prohibitions against post-claims un-
19 derwriting).

20 “(IX) Section 11 (relating to
21 minimum standards).

22 “(X) Section 12 (relating to re-
23 quirement to offer inflation protec-
24 tion), except that any requirement for
25 a signature on a rejection of inflation

1 protection shall permit the signature
2 to be on an application or on a separate form.
3

4 “(XI) Section 23 (relating to prohibition against preexisting conditions
5 and probationary periods in replacement policies or certificates).
6

7
8 “(ii) MODEL ACT.—The following requirements of the model Act:
9

10 “(I) Section 6C (relating to preexisting conditions).
11

12 “(II) Section 6D (relating to prior hospitalization).
13

14 “(B) DEFINITIONS.—For purposes of this
15 paragraph—

16 “(i) MODEL PROVISIONS.—The terms
17 ‘model regulation’ and ‘model Act’ mean
18 the long-term care insurance model regulation, and the long-term care insurance
19 model Act, respectively, promulgated by
20 the National Association of Insurance
21 Commissioners (as adopted as of January
22 1993).
23

24 “(ii) COORDINATION.—Any provision
25 of the model regulation or model Act listed

1 under clause (i) or (ii) of subparagraph
2 (A) shall be treated as including any other
3 provision of such regulation or Act nec-
4 essary to implement the provision.

5 “(iii) DETERMINATION.—For pur-
6 poses of this section and section 4980C,
7 the determination of whether any require-
8 ment of a model regulation or the model
9 Act has been met shall be made by the
10 Secretary.

11 “(3) DISCLOSURE REQUIREMENT.—The re-
12 quirement of this paragraph is met with respect to
13 any policy if such policy meets the requirements of
14 section 4980C(d)(1).

15 “(4) NONFORFEITURE REQUIREMENTS.—

16 “(A) IN GENERAL.—The requirements of
17 this paragraph are met with respect to any level
18 premium long-term care insurance policy, if the
19 issuer of such policy offers to the policyholder,
20 including any group policyholder, a
21 nonforfeiture provision meeting the require-
22 ments of subparagraph (B).

23 “(B) REQUIREMENTS OF PROVISION.—The
24 nonforfeiture provision required under subpara-

1 graph (A) shall meet the following require-
2 ments:

3 “(i) The nonforfeiture provision shall
4 be appropriately captioned.

5 “(ii) The nonforfeiture provision shall
6 provide for a benefit available in the event
7 of a default in the payment of any pre-
8 miums and the amount of the benefit may
9 be adjusted subsequent to being initially
10 granted only as necessary to reflect
11 changes in claims, persistency, and interest
12 as reflected in changes in rates for pre-
13 mium paying policies approved by the Sec-
14 retary for the same policy form.

15 “(iii) The nonforfeiture provision shall
16 provide at least one of the following:

17 “(I) Reduced paid-up insurance.

18 “(II) Extended term insurance.

19 “(III) Shortened benefit period.

20 “(IV) Other similar offerings ap-
21 proved by the Secretary.

22 “(5) LONG-TERM CARE INSURANCE POLICY DE-
23 FINED.—For purposes of this subsection, the term
24 ‘long-term care insurance policy’ has the meaning
25 given such term by section 4980C(e).”.

1 **SEC. 326. REQUIREMENTS FOR ISSUERS OF LONG-TERM**
2 **CARE INSURANCE POLICIES.**

3 (a) IN GENERAL.—Chapter 43 is amended by adding
4 at the end the following new section:

5 **“SEC. 4980C. REQUIREMENTS FOR ISSUERS OF LONG-TERM**
6 **CARE INSURANCE POLICIES.**

7 “(a) GENERAL RULE.—There is hereby imposed on
8 any person failing to meet the requirements of subsection
9 (c) or (d) a tax in the amount determined under sub-
10 section (b).

11 “(b) AMOUNT.—

12 “(1) IN GENERAL.—The amount of the tax im-
13 posed by subsection (a) shall be \$100 per policy for
14 each day any requirements of subsection (c) or (d)
15 are not met with respect to each long-term care in-
16 surance policy.

17 “(2) WAIVER.—In the case of a failure which is
18 due to reasonable cause and not to willful neglect,
19 the Secretary may waive part or all of the tax im-
20 posed by subsection (a) to the extent that payment
21 of the tax would be excessive relative to the failure
22 involved.

23 “(c) RESPONSIBILITIES.—The requirements of this
24 subsection are as follows:

25 “(1) REQUIREMENTS OF MODEL PROVISIONS.—

1 “(A) MODEL REGULATION.—The following
2 requirements of the model regulation must be
3 met:

4 “(i) Section 13 (relating to application
5 forms and replacement coverage).

6 “(ii) Section 14 (relating to reporting
7 requirements), except that the issuer shall
8 also report at least annually the number of
9 claims denied during the reporting period
10 for each class of business (expressed as a
11 percentage of claims denied), other than
12 claims denied for failure to meet the wait-
13 ing period or because of any applicable
14 preexisting condition.

15 “(iii) Section 20 (relating to filing re-
16 quirements for marketing).

17 “(iv) Section 21 (relating to standards
18 for marketing), including inaccurate com-
19 pletion of medical histories, other than sec-
20 tions 21C(1) and 21C(6) thereof, except
21 that—

22 “(I) in addition to such require-
23 ments, no person shall, in selling or
24 offering to sell a long-term care insur-

1 ance policy, misrepresent a material
2 fact; and

3 “(II) no such requirements shall
4 include a requirement to inquire or
5 identify whether a prospective appli-
6 cant or enrollee for long-term care in-
7 surance has accident and sickness in-
8 surance.

9 “(v) Section 22 (relating to appro-
10 priateness of recommended purchase).

11 “(vi) Section 24 (relating to standard
12 format outline of coverage).

13 “(vii) Section 25 (relating to require-
14 ment to deliver shopper’s guide).

15 “(B) MODEL ACT.—The following require-
16 ments of the model Act must be met:

17 “(i) Section 6F (relating to right to
18 return), except that such section shall also
19 apply to denials of applications and any re-
20 fund shall be made within 30 days of the
21 return or denial.

22 “(ii) Section 6G (relating to outline of
23 coverage).

24 “(iii) Section 6H (relating to require-
25 ments for certificates under group plans).

1 “(iv) Section 6I (relating to policy
2 summary).

3 “(v) Section 6J (relating to monthly
4 reports on accelerated death benefits).

5 “(vi) Section 7 (relating to incontest-
6 ability period).

7 “(C) DEFINITIONS.—For purposes of this
8 paragraph, the terms ‘model regulation’ and
9 ‘model Act’ have the meanings given such terms
10 by section 7702B(f)(2)(B).

11 “(2) DELIVERY OF POLICY.—If an application
12 for a long-term care insurance policy (or for a cer-
13 tificate under a group long-term care insurance pol-
14 icy) is approved, the issuer shall deliver to the appli-
15 cant (or policyholder or certificateholder) the policy
16 (or certificate) of insurance not later than 30 days
17 after the date of the approval.

18 “(3) INFORMATION ON DENIALS OF CLAIMS.—
19 If a claim under a long-term care insurance policy
20 is denied, the issuer shall, within 60 days of the date
21 of a written request by the policyholder or
22 certificateholder (or representative)—

23 “(A) provide a written explanation of the
24 reasons for the denial, and

1 “(B) make available all information di-
2 rectly relating to such denial.

3 “(d) DISCLOSURE.—The requirements of this sub-
4 section are met if the issuer of a long-term care insurance
5 policy discloses in such policy and in the outline of cov-
6 erage required under subsection (c)(1)(B)(ii) that the pol-
7 icy is intended to be a qualified long-term care insurance
8 contract under section 7702B(b).

9 “(e) LONG-TERM CARE INSURANCE POLICY DE-
10 FINED.—For purposes of this section, the term ‘long-term
11 care insurance policy’ means any product which is adver-
12 tised, marketed, or offered as long-term care insurance.”.

13 (b) CONFORMING AMENDMENT.—The table of sec-
14 tions for chapter 43 is amended by adding at the end the
15 following new item:

“Sec. 4980C. Requirements for issuers of long-term care insur-
 ance policies.”.

16 **SEC. 327. COORDINATION WITH STATE REQUIREMENTS.**

17 Nothing in this part shall prevent a State from estab-
18 lishing, implementing, or continuing in effect standards
19 related to the protection of policyholders of long-term care
20 insurance policies (as defined in section 4980C(e) of the
21 Internal Revenue Code of 1986), if such standards are not
22 in conflict with or inconsistent with the standards estab-
23 lished under such Code.

1 **SEC. 328. EFFECTIVE DATES.**

2 (a) IN GENERAL.—The provisions of, and amend-
3 ments made by, this part shall apply to contracts issued
4 after December 31, 1996. The provisions of section 321(g)
5 (relating to transition rule) shall apply to such contracts.

6 (b) ISSUERS.—The amendments made by section 326
7 shall apply to actions taken after December 31, 1996.

8 **Subtitle D—Treatment of**
9 **Accelerated Death Benefits**

10 **SEC. 331. TREATMENT OF ACCELERATED DEATH BENEFITS**
11 **BY RECIPIENT.**

12 (a) IN GENERAL.—Section 101 (relating to certain
13 death benefits) is amended by adding at the end the fol-
14 lowing new subsection:

15 “(g) TREATMENT OF CERTAIN ACCELERATED
16 DEATH BENEFITS.—

17 “(1) IN GENERAL.—For purposes of this sec-
18 tion, the following amounts shall be treated as an
19 amount paid by reason of the death of an insured:

20 “(A) Any amount received under a life in-
21 surance contract on the life of an insured who
22 is a terminally ill individual.

23 “(B) Any amount received under a life in-
24 surance contract on the life of an insured who
25 is a chronically ill individual (as determined in
26 such manner as the Secretary may prescribe)

1 but only if such amount is received under a
2 rider or other provision of such contract which
3 is treated as a qualified long-term care insur-
4 ance contract under section 7702B.

5 “(2) TREATMENT OF VIATICAL SETTLE-
6 MENTS.—

7 “(A) IN GENERAL.—In the case of a life
8 insurance contract on the life of an insured de-
9 scribed in paragraph (1), if—

10 “(i) any portion of such contract is
11 sold to any viatical settlement provider, or

12 “(ii) any portion of the death benefit
13 is assigned to such a provider,
14 the amount paid for such sale or assignment
15 shall be treated as an amount paid under the
16 life insurance contract by reason of the death of
17 such insured.

18 “(B) VIATICAL SETTLEMENT PROVIDER.—
19 The term ‘viatical settlement provider’ means
20 any person regularly engaged in the trade or
21 business of purchasing, or taking assignments
22 of, life insurance contracts on the lives of
23 insureds described in paragraph (1) if—

1 “(i) such person is licensed for such
2 purposes in the State in which the insured
3 resides, or

4 “(ii) in the case of an insured who re-
5 sides in a State not requiring the licensing
6 of such persons for such purposes—

7 “(I) such person meets the re-
8 quirements of sections 8 and 9 of the
9 Viatical Settlements Model Act of the
10 National Association of Insurance
11 Commissioners, and

12 “(II) meets the requirements of
13 the Model Regulations of the National
14 Association of Insurance Commis-
15 sioners (relating to standards for eval-
16 uation of reasonable payments) in de-
17 termining amounts paid by such per-
18 son in connection with such purchases
19 or assignments.

20 “(3) DEFINITIONS.—For purposes of this sub-
21 section—

22 “(A) TERMINALLY ILL INDIVIDUAL.—The
23 term ‘terminally ill individual’ means an indi-
24 vidual who has been certified by a physician as
25 having an illness or physical condition which

1 can reasonably be expected to result in death in
 2 24 months or less after the date of the certifi-
 3 cation.

4 “(B) PHYSICIAN.—The term ‘physician’
 5 has the meaning given to such term by section
 6 1861(r)(1) of the Social Security Act (42
 7 U.S.C. 1395x(r)(1)).

8 “(4) EXCEPTION FOR BUSINESS-RELATED POLI-
 9 CIES.—This subsection shall not apply in the case of
 10 any amount paid to any taxpayer other than the in-
 11 sured if such taxpayer has an insurable interest with
 12 respect to the life of the insured by reason of the in-
 13 sured being a director, officer, or employee of the
 14 taxpayer or by reason of the insured being finan-
 15 cially interested in any trade or business carried on
 16 by the taxpayer.”

17 (b) EFFECTIVE DATE.—The amendment made by
 18 subsection (a) shall apply to amounts received after De-
 19 cember 31, 1996.

20 **SEC. 332. TAX TREATMENT OF COMPANIES ISSUING QUALI-**
 21 **FIED ACCELERATED DEATH BENEFIT RID-**
 22 **ERS.**

23 (a) QUALIFIED ACCELERATED DEATH BENEFIT RID-
 24 ERS TREATED AS LIFE INSURANCE.—Section 818 (relat-

ing to other definitions and special rules) is amended by
 adding at the end the following new subsection:

“(g) QUALIFIED ACCELERATED DEATH BENEFIT
 RIDERS TREATED AS LIFE INSURANCE.—For purposes of
 this part—

“(1) IN GENERAL.—Any reference to a life in-
 surance contract shall be treated as including a ref-
 erence to a qualified accelerated death benefit rider
 on such contract.

“(2) QUALIFIED ACCELERATED DEATH BENE-
 FIT RIDERS.—For purposes of this subsection, the
 term ‘qualified accelerated death benefit rider’
 means any rider on a life insurance contract if the
 only payments under the rider are payments meeting
 the requirements of section 101(g).

“(3) EXCEPTION FOR LONG-TERM CARE RID-
 ERS.—Paragraph (1) shall not apply to any rider
 which is treated as a long-term care insurance con-
 tract under section 7702B.”

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by
 this section shall take effect on January 1, 1997.

(2) ISSUANCE OF RIDER NOT TREATED AS MA-
 TERIAL CHANGE.—For purposes of applying sections

1 101(f), 7702, and 7702A of the Internal Revenue
2 Code of 1986 to any contract—

3 (A) the issuance of a qualified accelerated
4 death benefit rider (as defined in section 818(g)
5 of such Code (as added by this Act)), and

6 (B) the addition of any provision required
7 to conform an accelerated death benefit rider to
8 the requirements of such section 818(g),
9 shall not be treated as a modification or material
10 change of such contract.

11 **Subtitle E—High-Risk Pools**

12 **SEC. 341. EXEMPTION FROM INCOME TAX FOR STATE-SPON-** 13 **SORED ORGANIZATIONS PROVIDING HEALTH** 14 **COVERAGE FOR HIGH-RISK INDIVIDUALS.**

15 (a) IN GENERAL.—Subsection (c) of section 501 (re-
16 lating to list of exempt organizations) is amended by add-
17 ing at the end the following new paragraph:

18 “(26) Any membership organization if—

19 “(A) such organization is established by a
20 State exclusively to provide coverage for medical
21 care (as defined in section 213(d)) on a not-for-
22 profit basis to individuals described in subpara-
23 graph (B) through—

24 “(i) insurance issued by the organiza-
25 tion, or

1 “(ii) a health maintenance organiza-
2 tion under an arrangement with the orga-
3 nization,

4 “(B) the only individuals receiving such
5 coverage through the organization are individ-
6 uals—

7 “(i) who are residents of such State,
8 and

9 “(ii) who, by reason of the existence
10 or history of a medical condition, are un-
11 able to acquire medical care coverage for
12 such condition through insurance or from
13 a health maintenance organization or are
14 able to acquire such coverage only at a
15 rate which is substantially in excess of the
16 rate for such coverage through the mem-
17 bership organization,

18 “(C) the composition of the membership in
19 such organization is specified by such State,
20 and

21 “(D) no part of the net earnings of the or-
22 ganization inures to the benefit of any private
23 shareholder or individual.”

1 (b) EFFECTIVE DATE.—The amendment made by
 2 this section shall apply to taxable years beginning after
 3 December 31, 1996.

4 **TITLE IV—REVENUE OFFSETS**

5 **SEC. 400. AMENDMENT OF 1986 CODE.**

6 Except as otherwise expressly provided, whenever in
 7 this title an amendment or repeal is expressed in terms
 8 of an amendment to, or repeal of, a section or other provi-
 9 sion, the reference shall be considered to be made to a
 10 section or other provision of the Internal Revenue Code
 11 of 1986.

12 **Subtitle A—Repeal of Bad Debt Re-** 13 **serve Method for Thrift Savings** 14 **Associations**

15 **SEC. 401. REPEAL OF BAD DEBT RESERVE METHOD FOR** 16 **THRIFT SAVINGS ASSOCIATIONS.**

17 (a) IN GENERAL.—Section 593 (relating to reserves
 18 for losses on loans) is amended by adding at the end the
 19 following new subsections:

20 “(f) TERMINATION OF RESERVE METHOD.—Sub-
 21 sections (a), (b), (c), and (d) shall not apply to any taxable
 22 year beginning after December 31, 1995.

23 “(g) 6-YEAR SPREAD OF ADJUSTMENTS.—

1 “(1) IN GENERAL.—In the case of any taxpayer
2 who is required by reason of subsection (f) to change
3 its method of computing reserves for bad debts—

4 “(A) such change shall be treated as a
5 change in a method of accounting,

6 “(B) such change shall be treated as initi-
7 ated by the taxpayer and as having been made
8 with the consent of the Secretary, and

9 “(C) the net amount of the adjustments
10 required to be taken into account by the tax-
11 payer under section 481(a)—

12 “(i) shall be determined by taking into
13 account only applicable excess reserves,
14 and

15 “(ii) as so determined, shall be taken
16 into account ratably over the 6-taxable
17 year period beginning with the first taxable
18 year beginning after December 31, 1995.

19 “(2) APPLICABLE EXCESS RESERVES.—

20 “(A) IN GENERAL.—For purposes of para-
21 graph (1), the term ‘applicable excess reserves’
22 means the excess (if any) of—

23 “(i) the balance of the reserves de-
24 scribed in subsection (c)(1) (other than the
25 supplemental reserve) as of the close of the

1 taxpayer's last taxable year beginning be-
2 fore December 31, 1995, over

3 “(ii) the lesser of—

4 “(I) the balance of such reserves
5 as of the close of the taxpayer's last
6 taxable year beginning before January
7 1, 1988, or

8 “(II) the balance of the reserves
9 described in subclause (I), reduced in
10 the same manner as under section
11 585(b)(2)(B)(ii) on the basis of the
12 taxable years described in clause (i)
13 and this clause.

14 “(B) SPECIAL RULE FOR THRIFTS WHICH
15 BECOME SMALL BANKS.—In the case of a bank
16 (as defined in section 581) which was not a
17 large bank (as defined in section 585(c)(2)) for
18 its first taxable year beginning after December
19 31, 1995—

20 “(i) the balance taken into account
21 under subparagraph (A)(ii) shall not be
22 less than the amount which would be the
23 balance of such reserves as of the close of
24 its last taxable year beginning before such
25 date if the additions to such reserves for

1 all taxable years had been determined
2 under section 585(b)(2)(A), and

3 “(ii) the opening balance of the re-
4 serve for bad debts as of the beginning of
5 such first taxable year shall be the balance
6 taken into account under subparagraph
7 (A)(ii) (determined after the application of
8 clause (i) of this subparagraph).

9 The preceding sentence shall not apply for pur-
10 poses of paragraphs (5) and (6) or subsection
11 (e)(1).

12 “(3) RECAPTURE OF PRE-1988 RESERVES
13 WHERE TAXPAYER CEASES TO BE BANK.—If, during
14 any taxable year beginning after December 31,
15 1995, a taxpayer to which paragraph (1) applied is
16 not a bank (as defined in section 581), paragraph
17 (1) shall apply to the reserves described in para-
18 graph (2)(A)(ii) except that such reserves shall be
19 taken into account ratably over the 6-taxable year
20 period beginning with such taxable year.

21 “(4) SUSPENSION OF RECAPTURE IF RESIDEN-
22 TIAL LOAN REQUIREMENT MET.—

23 “(A) IN GENERAL.—In the case of a bank
24 which meets the residential loan requirement of
25 subparagraph (B) for the first taxable year be-

1 ginning after December 31, 1995 or for the fol-
2 lowing taxable year—

3 “(i) no adjustment shall be taken into
4 account under paragraph (1) for such tax-
5 able year, and

6 “(ii) such taxable year shall be dis-
7 regarded in determining—

8 “(I) whether any other taxable
9 year is a taxable year for which an
10 adjustment is required to be taken
11 into account under paragraph (1), and

12 “(II) the amount of such adjust-
13 ment.

14 “(B) RESIDENTIAL LOAN REQUIRE-
15 MENT.—A taxpayer meets the residential loan
16 requirement of this subparagraph for any tax-
17 able year if the principal amount of the residen-
18 tial loans made by the taxpayer during such
19 year is not less than the base amount for such
20 year.

21 “(C) RESIDENTIAL LOAN.—For purposes
22 of this paragraph, the term ‘residential loan’
23 means any loan described in clause (v) of sec-
24 tion 7701(a)(19)(C) but only if such loan is in-

1 curred in acquiring, constructing, or improving
2 the property described in such clause.

3 “(D) BASE AMOUNT.—For purposes of
4 subparagraph (B), the base amount is the aver-
5 age of the principal amounts of the residential
6 loans made by the taxpayer during the 6 most
7 recent taxable years beginning on or before De-
8 cember 31, 1995. At the election of the tax-
9 payer who made such loans during each of such
10 6 taxable years, the preceding sentence shall be
11 applied without regard to the taxable year in
12 which such principal amount was the highest
13 and the taxable year in such principal amount
14 was the lowest. Such an election may be made
15 only for the first taxable year beginning after
16 such date, and, if made for such taxable year,
17 shall apply to the succeeding taxable year un-
18 less revoked with the consent of the Secretary.

19 “(E) CONTROLLED GROUPS.—In the case
20 of a taxpayer which is a member of any con-
21 trolled group of corporations described in sec-
22 tion 1563(a)(1), subparagraph (B) shall be ap-
23 plied with respect to such group.

24 “(5) CONTINUED APPLICATION OF FRESH
25 START UNDER SECTION 585 TRANSITIONAL RULES.—

1 In the case of a taxpayer to which paragraph (1) ap-
2 plied and which was not a large bank (as defined in
3 section 585(c)(2)) for its first taxable year beginning
4 after December 31, 1995:

5 “(A) IN GENERAL.—For purposes of deter-
6 mining the net amount of adjustments referred
7 to in section 585(c)(3)(A)(iii), there shall be
8 taken into account only the excess (if any) of
9 the reserve for bad debts as of the close of the
10 last taxable year before the disqualification year
11 over the balance taken into account by such
12 taxpayer under paragraph (2)(A)(ii) of this sub-
13 section.

14 “(B) TREATMENT UNDER ELECTIVE CUT-
15 OFF METHOD.—For purposes of applying sec-
16 tion 585(c)(4)—

17 “(i) the balance of the reserve taken
18 into account under subparagraph (B)
19 thereof shall be reduced by the balance
20 taken into account by such taxpayer under
21 paragraph (2)(A)(ii) of this subsection,
22 and

23 “(ii) no amount shall be includible in
24 gross income by reason of such reduction.

1 “(6) SUSPENDED RESERVE INCLUDED AS SEC-
2 TION 381(c) ITEM.—The balance taken into account
3 by a taxpayer under paragraph (2)(A)(ii) of this
4 subsection shall be treated as an item described in
5 section 381(c).

6 “(7) CONVERSIONS TO CREDIT UNIONS.—In the
7 case of a taxpayer to which paragraph (1) applied
8 which becomes a credit union described in section
9 501(c) and exempt from taxation under section
10 501(a)—

11 “(A) any amount required to be included
12 in the gross income of the credit union by rea-
13 son of this subsection shall be treated as de-
14 rived from an unrelated trade or business (as
15 defined in section 513), and

16 “(B) for purposes of paragraph (3), the
17 credit union shall not be treated as if it were
18 a bank.

19 “(8) REGULATIONS.—The Secretary shall pre-
20 scribe such regulations as may be necessary to carry
21 out this subsection and subsection (e), including reg-
22 ulations providing for the application of such sub-
23 sections in the case of acquisitions, mergers, spin-
24 offs, and other reorganizations.”

25 (b) CONFORMING AMENDMENTS.—

1 (1) Subsection (d) of section 50 is amended by
2 adding at the end the following new sentence:
3 “Paragraphs (1)(A), (2)(A), and (4) of the section 46(e)
4 referred to in paragraph (1) of this subsection shall not
5 apply to any taxable year beginning after December 31,
6 1995.”

7 (2) Subsection (e) of section 52 is amended by
8 striking paragraph (1) and by redesignating para-
9 graphs (2) and (3) as paragraphs (1) and (2), re-
10 spectively.

11 (3) Subsection (a) of section 57 is amended by
12 striking paragraph (4).

13 (4) Section 246 is amended by striking sub-
14 section (f).

15 (5) Clause (i) of section 291(e)(1)(B) is amend-
16 ed by striking “or to which section 593 applies”.

17 (6) Subparagraph (A) of section 585(a)(2) is
18 amended by striking “other than an organization to
19 which section 593 applies”.

20 (7)(A) The material preceding subparagraph
21 (A) of section 593(e)(1) is amended by striking “by
22 a domestic building and loan association or an insti-
23 tution that is treated as a mutual savings bank
24 under section 591(b)” and inserting “by a taxpayer

1 having a balance described in subsection
2 (g)(2)(A)(ii)’’.

3 (B) Subparagraph (B) of section 593(e)(1) is
4 amended to read as follows:

5 “(B) then out of the balance taken into ac-
6 count under subsection (g)(2)(A)(ii) (properly
7 adjusted for amounts charged against such re-
8 serves for taxable years beginning after Decem-
9 ber 31, 1987),’’.

10 (C) Paragraph (1) of section 593(e) is amended
11 by adding at the end the following new sentence:
12 “‘This paragraph shall not apply to any distribution
13 of all of the stock of a bank (as defined in section
14 581) to another corporation if, immediately after the
15 distribution, such bank and such other corporation
16 are members of the same affiliated group (as defined
17 in section 1504) and the provisions of section 5(e)
18 of the Federal Deposit Insurance Act (as in effect
19 on December 31, 1995) or similar provisions are in
20 effect.’”

21 (8) Section 595 is hereby repealed.

22 (9) Section 596 is hereby repealed.

23 (10) Subsection (a) of section 860E is amend-
24 ed—

1 (A) by striking “Except as provided in
2 paragraph (2), the” in paragraph (1) and in-
3 serting “The”,

4 (B) by striking paragraphs (2) and (4) and
5 redesignating paragraphs (3) and (5) as para-
6 graphs (2) and (3), respectively, and

7 (C) by striking in paragraph (2) (as so re-
8 designated) all that follows “subsection” and
9 inserting a period.

10 (11) Paragraph (3) of section 992(d) is amend-
11 ed by striking “or 593”.

12 (12) Section 1038 is amended by striking sub-
13 section (f).

14 (13) Clause (ii) of section 1042(c)(4)(B) is
15 amended by striking “or 593”.

16 (14) Subsection (c) of section 1277 is amended
17 by striking “or to which section 593 applies”.

18 (15) Subparagraph (B) of section 1361(b)(2) is
19 amended by striking “or to which section 593 ap-
20 plies”.

21 (16) The table of sections for part II of sub-
22 chapter H of chapter 1 is amended by striking the
23 items relating to sections 595 and 596.

24 (c) EFFECTIVE DATE.—

1 (1) IN GENERAL.—Except as otherwise pro-
 2 vided in this subsection, the amendments made by
 3 this section shall apply to taxable years beginning
 4 after December 31, 1995.

5 (2) SUBSECTION (b)(7).—The amendments
 6 made by subsection (b)(7) shall not apply to any dis-
 7 tribution with respect to preferred stock if—

8 (A) such stock is outstanding at all times
 9 after October 31, 1995, and before the distribu-
 10 tion, and

11 (B) such distribution is made before the
 12 date which is 1 year after the date of the enact-
 13 ment of this Act.

14 (3) SUBSECTION (b)(10).—The amendments
 15 made by subsection (b)(10) shall not apply to any
 16 residual interest held by a taxpayer if such interest
 17 has been held by such taxpayer at all times after Oc-
 18 tober 31, 1995.

19 **Subtitle B—Reform of the Earned** 20 **Income Credit**

21 **SEC. 411. EARNED INCOME CREDIT DENIED TO INDIVID-** 22 **UALS NOT AUTHORIZED TO BE EMPLOYED IN** 23 **THE UNITED STATES.**

24 (a) IN GENERAL.—Section 32(c)(1) (relating to indi-
 25 viduals eligible to claim the earned income credit) is

1 amended by adding at the end the following new subpara-
2 graph:

3 “(F) IDENTIFICATION NUMBER REQUIRE-
4 MENT.—The term ‘eligible individual’ does not
5 include any individual who does not include on
6 the return of tax for the taxable year—

7 “(i) such individual’s taxpayer identi-
8 fication number, and

9 “(ii) if the individual is married (with-
10 in the meaning of section 7703), the tax-
11 payer identification number of such indi-
12 vidual’s spouse.”.

13 (b) SPECIAL IDENTIFICATION NUMBER.—Section 32
14 is amended by adding at the end the following new sub-
15 section:

16 “(l) IDENTIFICATION NUMBERS.—Solely for pur-
17 poses of subsections (c)(1)(F) and (c)(3)(D), a taxpayer
18 identification number means a social security number is-
19 sued to an individual by the Social Security Administra-
20 tion (other than a social security number issued pursuant
21 to clause (II) (or that portion of clause (III) that relates
22 to clause (II)) of section 205(c)(2)(B)(i) of the Social Se-
23 curity Act).”.

24 (c) EXTENSION OF PROCEDURES APPLICABLE TO
25 MATHEMATICAL OR CLERICAL ERRORS.—Section

1 6213(g)(2) (relating to the definition of mathematical or
 2 clerical errors) is amended by striking “and” at the end
 3 of subparagraph (D), by striking the period at the end
 4 of subparagraph (E) and inserting a comma, and by in-
 5 serting after subparagraph (E) the following new subpara-
 6 graphs:

7 “(F) an omission of a correct taxpayer
 8 identification number required under section 32
 9 (relating to the earned income credit) to be in-
 10 cluded on a return, and

11 “(G) an entry on a return claiming the
 12 credit under section 32 with respect to net
 13 earnings from self-employment described in sec-
 14 tion 32(c)(2)(A) to the extent the tax imposed
 15 by section 1401 (relating to self-employment
 16 tax) on such net earnings has not been paid.”.

17 (d) EFFECTIVE DATE.—The amendments made by
 18 this section shall apply to taxable years beginning after
 19 December 31, 1995.

20 **SEC. 412. PROVISIONS TO IMPROVE TAX COMPLIANCE.**

21 (a) INCREASE IN PENALTIES FOR RETURN PREPAR-
 22 ERS.—

23 (1) UNDERSTATEMENT PENALTY.—Section
 24 6694 (relating to understatement of income tax li-
 25 ability by income tax return preparer) is amended—

1 (A) by striking “\$250” in subsection (a)
2 and inserting “\$500”, and

3 (B) by striking “\$1,000” in subsection (b)
4 and inserting “\$2,000”.

5 (2) OTHER ASSESSABLE PENALTIES.—Section
6 6695 (relating to other assessable penalties) is
7 amended—

8 (A) by striking “\$50” and “\$25,000” in
9 subsections (a), (b), (c), (d), and (e) and insert-
10 ing “\$100” and “\$50,000”, respectively, and

11 (B) by striking “\$500” in subsection (f)
12 and inserting “\$1,000”.

13 (b) AIDING AND ABETTING PENALTY.—Section
14 6701(b) (relating to amount of penalty) is amended—

15 (1) by striking “\$1,000” in paragraph (1) and
16 inserting “\$2,000”, and

17 (2) by striking “\$10,000” in paragraph (2) and
18 inserting “\$20,000”.

19 (c) EFFECTIVE DATE.—The amendments made by
20 this section shall apply to penalties with respect to taxable
21 years beginning after December 31, 1995.

○